A USERS MANUAL

FOR SUBSTANCE ABUSE

TREATMENT COUNSELORS

AND COMPUTER ENTRY

PERSONNEL

FISCAL YEAR 2014

DARTS

DIVISION OF ALCOHOLISM AND SUBSTANCE ABUSE AUTOMATED REPORTING AND TRACKING SYSTEM (DARTS)

ILLINOIS
DEPARTMENT OF
HUMAN SERVICES

Division of
Alcoholism and
Substance Abuse

TROUBLESHOOTING/DASA HELP DESK

For questions or problems concerning the use of the DARTS software, please refer to this manual before contacting the department. This is the quickest way to find answers. Check also the DASA Web Page at http://www.dhs.state.il.us/page.aspx?item=29747 as this site contains many reference materials. If problems cannot be resolved, Section IX of this manual contains guidelines for documentation of the problem and for contacting the DASA Help Desk at DHS.DASAHelp@illinois.gov or faxing to 217-558-4656.

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SECTION I

How to Get Started

What is DARTS and How is it Used?

The Department's Automated Reporting and Tracking System (DARTS) is a software program used to report funded and/or Medicaid certified addiction intervention and treatment services as authorized by the Division of Alcoholism and Substance Abuse (DASA). Information extracted from DARTS is used to authorize grant fixed rate and fee-for-service payments, reconcile advance and reconcile disbursements, and determine compliance with State and Federal reporting requirements. Additionally, data extracted from DARTS is used to determine treatment and intervention service delivery patterns for budgetary purposes, measure outcomes and assist with long term planning. It is critically important that data is submitted correctly and in accordance with submission time frames.

How and When is Data Submitted?

All DARTS data must be submitted electronically using the DHS Intranet. At a minimum, data must be submitted monthly but can be submitted daily if desired. All data is processed weekly as of 5:00 p.m. on Monday of each week.

When Do I Get Paid?

Payments are authorized monthly by DASA. Grant fixed rate and Fee-for-service payments are based upon actual data received and accepted by DASA as of 5:00 p.m. of every second Monday of each month. Submissions not received in this time frame are used to authorize payment in the following month. Pre-approved Advance and Reconcile payments are authorized monthly and are reconciled to service submissions periodically, and at the end of the fiscal year.

How Do I Get Started?

Directions for loading and updating software are provided with the software. The four-digit provider number and initial password (DARTS) are also provided and are needed to begin using DARTS. Once the provider number is entered, it will automatically appear on any other screen where the number is required. Upon entry into DARTS, the password can be changed to identify a unique password for the organization.

What Information Should Be Entered into DARTS?

DASA uses DARTS information to analyze its funded service delivery system and to extract information for grant fixed rate and fee-for-service payments and Advance and Reconcile funding reconciliation. All payments and reconciliations are based upon funding contained in a contract with DASA. The only services that should be entered into DARTS are those that are to be reimbursed by Medicaid or those that are to be reimbursed from or reconciled against DASA non-Medicaid currently awarded funding.

What is the Process for Obtaining Information to Input into DARTS?

Hard copy data input forms are provided to use with DARTS software. It is strongly suggested that these forms be completed by clinical or other organization staff to document reportable and/or billable services **prior** to any entry into DARTS. Additionally, all individuals who complete and/or enter data from these forms should thoroughly read and understand the definition for each field on every form prior to use of the forms or the software.

Where Do I Start?

All entry into DARTS begins with the main menu bar and the following six options:

1. **Client/Patient Demographics (Openings/Closings)** - Used to record opening demographics, fix demographic errors and to record closing information and discharge outcomes.
2. **Services** - Used to report services.
3. **Unit/Program File** - Used to view unit number and program codes, funding codes and procedure codes.
4. **Reports** - Used to print and view reports.
5. **Utilities** - Used to submit service data to DASA, change passwords and load updates.
6. **DARTS Information** - Verifies the software version.

What are the Keyboard Functions?

Enter

Selected to save data and move forward through the screens. DATA IS NOT SAVED UNLESS THE MESSAGE **"TRANSACTION SUCCESSFUL"** IS DISPLAYED!

Escape

Selected to escape from any data input screen and back to the Menu Screen. In the process of entering data on a screen, selection of ESCAPE will display a message "ARE YOU SURE? (Y/N)." Responding "Y" will lose data entered on the most recent entry only! Responding "N" will allow continuation with the transaction.

F1

If selected, data in the demographic or service screens is displayed regarding the individual fields.

F2

If selected, will allow duplication of all the data for the same client/patient entered from the previous transaction except for the day the service was provided.

F3

This option is available on all service reporting screens except Level III. It will allow duplication of all the data entered from the previous transaction except for the client/patient identification. This is particularly helpful when entering group services.

F5

As applicable, is used to go backwards to the previous data input screen.

Tab ➜ moves to the next field.
Shift-tab ➜ moves to the previous field.

What are National Outcome Measures (NOMs) and How do They Relate to DARTS?

National Outcome Measures are domains established by the federal government to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery from addiction related disorders. DARTS collects information about these domains at admission and discharge from most levels of care within an episode of care. This data is submitted in aggregate to the federal government and also used by DASA for analysis and process improvement. Outcome measures that are used to analyze change from admission to discharge are identified in DARTS as NOMs.

Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year-to-year. All addresses should match those specified on DASA facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify DASA immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Dedicated Funding Category Window (Non-Medicaid)

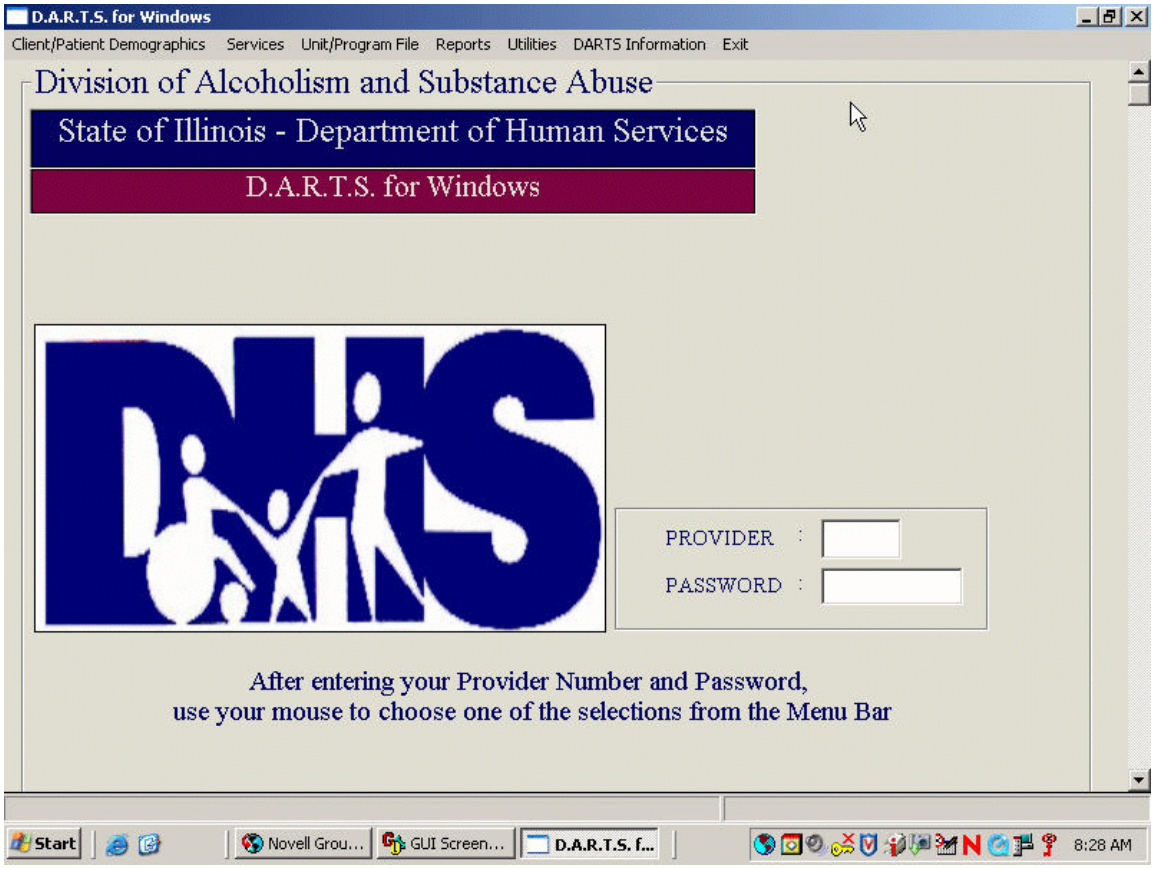
Dedicated funding is contained in many DASA contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of "DC" or "DS" can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

D - DCFS
G - OMT Toxicology
L - Gambling
N - None

Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding, but the service being reported does not apply to the patient, select "N" for none. It is very important that dedicated funding is reported correctly. This is how DASA measures compliance with the contract and these amounts are reflected on special dedicated funding reports.

Data Submission Errors

Specific error messages are displayed on the "Client Master File Update" and "Services Accepted/Rejected" reports that are posted on Mobius. When you receive an error message, the first step is READ the message and correct the problem. The DASA Help Desk should be contacted only after you have read the report and tried to fix the problem. Some of the most common errors and directions on how to correct them and avoid them in the future are specified in Section XI of this manual.



Demographics

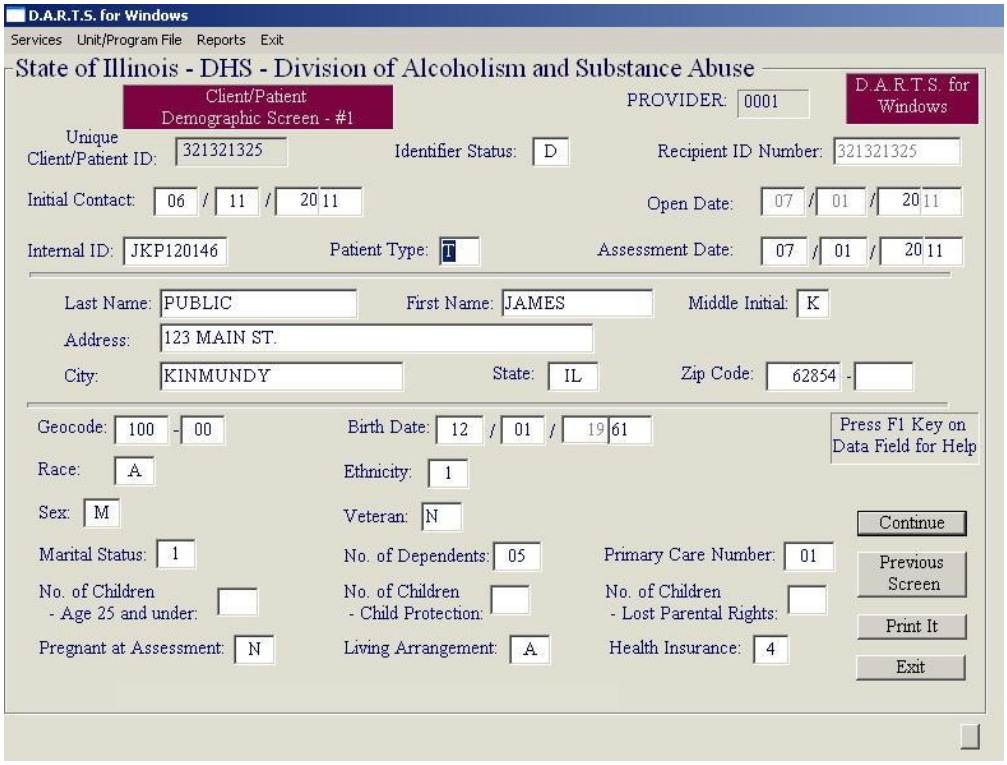
How Do I Enter Information into DARTS?

Information is entered into DARTS using the main menu and any of its data entry options. All early intervention and treatment services require a client/patient demographic record and this must be completed before any services can be entered. Community Intervention and HIV Early Intervention are the only two reportable services that do not require demographics.

OPENING: How is a Client/Patient Opened into DARTS?

Demographics are required for each episode of care. Episode of care means the period of service between the beginning of a service for an alcohol or drug problem and the termination of services for the prescribed intervention or treatment plan. The first event in this episode is an admission and the last event is a discharge. Any change in service within the same Provider during a treatment episode is considered a discharge with a transfer code selected as the reason. Demographics required for opening are initially collected and recorded on the "Client/Patient Opening" data input form. The information contained on this form is then used to input the data into DARTS. The fields contained on each demographic screen are identified and defined as follows:

DEMOGRAPHIC SCREEN 1



Unique Client/Patient Identifier (NOMs)

This is a key field for DARTS as it holds the number that identifies the client/patient as unique in our system and across other systems of care. This number is essential to state and federal government for the measurement of outcomes, the ability to track clients/patients who receive services from multiple agencies and to ensure that duplicate services are not billed for the same client/patient. For existing clients/patients who

have been receiving services with no interruption over the past few fiscal years, this number might still be the social security number or a generated identification number. **However, the Recipient Identification Number (RIN) assigned by DASA is the preferred unique identifier and must be used for any new admission.**

Identifier Status

This field contains additional information concerning the status of the unique identifier.

A - The SSN is the identifier
B - The service recipient does not have a SSN
C - The SSN was not obtained before termination of service
D - The RIN is being used as the unique identifier
For clients opened after 6/30/07, Identifier Status must be "D"

Recipient Identification Number (RIN)

When using the DHS eRIN web site to obtain a RIN, use the patient's legal name, if possible. This will help to prevent the assignment of multiple RINs for a patient. Enter the 9-digit number assigned to the individual by DHS or as indicated on the Medical Eligibility Card. This recipient number is comprised of a mathematical computation and is required for all clients/patients. Please go to http://www.dhs.state.il.us/page.aspx?item=32574 for information on obtaining RINs. **Entering any of the nine digits incorrectly will display the error message "Invalid RIN Computed." Note: If the RIN is used as the unique identifier, it will automatically default to this field.**

Initial Date of Contact (NOMs)

The date of the initial contact means the first request for an early intervention or treatment service for the current episode of care, in which an appointment is made by the client/patient or someone on behalf of the client/patient. **NOTE: This date keys to a critical outcome measure related to the amount of time elapsed between the initial contact, the assessment, and the first intervention or treatment service**. Please ensure that this date is entered correctly. **This date SHOULD NOT be the date of the first assessment, early intervention, or treatment service unless that was the actual first contact with the client/patient.**

Open Date

This is a key field for DARTS. It means the first date of service for the episode of care. For billing purposes, this is the first date that a service can be billed. Any bill submitted with a date that precedes the opening date will be rejected.

Internal ID

An **optional** field to record a second identification number for the client/patient that may be used only by the provider.

Client/Patient Type

In this field, the type of client/patient is identified. "T" should be selected for an individual who will be receiving a Recovery Home service and/or who has completed the assessment, has a diagnosis of abuse or dependence and who is recommended for admission to a DASA funded **treatment** service. "I" should be selected for an individual who has completed the assessment, has no diagnosis and who is recommended for admission to a DASA funded **early intervention** service. "O" should be selected only for closure of patient demographic record opened prior to July 1, 2004 for which all demographic discharge information cannot be obtained.

Assessment Date (NOMs)

This field collected in the client/patient demographic record and means the first date of the process required by Administrative Rule, Part 2060 to collect and interpret information from a client/patient to make an initial determination of alcohol abuse or dependence and to make a recommendation for placement into intervention or treatment services. For DASA, this date is used as a process improvement measurement to determine the time elapsed between the start of the assessment and the first clinical service. For data collection purposes, this date can precede the opening date. For billing purposes, it cannot. If the assessment is billed to DASA through DARTS, this date should match the first assessment billing date. Additionally, this date will default to the discharge date for any admission assessment that results in a problem area of "#5" - None.

Name (L, F, MI), Street Address, City, State, Zip Code

Geocode/County Code Quick Reference

Geocode is a five-digit number, which correctly identifies the county and township/community area. The first three positions identify the county and the next two identify the township/community area. Refer to the current Directory of Geographic Information published by the State of Illinois to find a geocode.

The corresponding three-digit code is specified for each county in Illinois and is a required field on the demographic screens in DSRS. A specific code (#103) is also given for out-of-state.

Geocode for **Chicago** begins with 105 and the Community Area is to be looked up in the Geocode Manual. Geocode for Suburban Cook begins with 016 and the Township is to be looked up in the Geocode Manual. Also, please spell Chicago "**CHICAGO**." Do not use CHGO, CGO, etc.

Code	County	Code	County	Code	County
001	Adams	036	Henderson	071	Ogle
002	Alexander	037	Henry	072	Peoria
003	Bond	038	Iroquois	073	Perry
004	Boone	039	Jackson	074	Piatt
005	Brown	040	Jasper	075	Pike
006	Bureau	041	Jefferson	076	Pope
007	Calhoun	042	Jersey	077	Pulaski
008	Carroll	043	Jo Daviess	078	Putnam
009	Cass	044	Johnson	079	Randolph
010	Champaign	045	Kane	080	Richland
011	Christian	046	Kankakee	081	Rock Island
012	Clark	047	Kendall	082	Saline
013	Clay	048	Knox	083	Sangamon
014	Clinton	049	Lake	084	Schuyler
015	Coles	050	LaSalle	085	Scott
016	Cook (Suburb)	051	Lawrence	086	Shelby
017	Crawford	052	Lee	087	Stark
018	Cumberland	053	Livingston	088	St. Clair
019	DeKalb	054	Logan	089	Stephenson
020	DeWitt	055	Macon	090	Tazewell
021	Douglas	056	Macoupin	091	Union
022	DuPage	057	Madison	092	Vermilion
023	Edgar	058	Marion	093	Wabash
024	Edwards	059	Marshall	094	Warren
025	Effingham	060	Mason	095	Washington
026	Fayette	061	Massac	096	Wayne
027	Ford	062	McDonough	097	White
028	Franklin	063	McHenry	098	Whiteside
029	Fulton	064	McLean	099	Will
030	Gallatin	065	Menard	100	Williamson
031	Greene	066	Mercer	101	Winnebago
032	Grundy	067	Monroe	102	Woodford
033	Hamilton	068	Montgomery	103	Out-of-State
034	Hancock	069	Morgan	104	Unknown
035	Hardin	070	Moultrie	105	**CHICAGO** (City)

Birth Date

The numeric equivalent of month, day, and year (MM/DD/YYYY).

Race

A - American Indian
B - Alaska Native
C - Asian
D - Native Hawaiian or other Pacific Islander
E - Black or African American
F - White
L - Other Single Race

Ethnicity

1 - Puerto Rican - of Puerto Rican origin regardless of race
2 - Mexican - of Mexican origin regardless of race
3 - Cuban - of Cuban origin regardless of race
4 - Other Specific Hispanic/Latino - of known Central or South American or any other Spanish cultural origin (including Spain), other than Puerto Rican, Mexican, or Cuban, regardless of race
5 - Not of Hispanic/Latino Origin
6 - Hispanic/Latino - Specific Origin Not Specified - of Hispanic/Latino origin but specific origin not known or not specified

Sex

Identifies the gender of the client/patient. Enter 'M' - Male or 'F' - Female.

Veteran

Indicates whether the client/patient has served in the Uniformed Services. Enter 'Y' - Yes or 'N' - No.

Marital Status

1 - Never Married
2 - Married
3 - Widowed
4 - Divorced
5 - Separated

Number of Dependents for Income Eligibility

The number of dependents living in the immediate household as well as any for whom financial responsibility exists.

Total Number of Children for Whom the Patient is the Primary Care Giver

The number of children, under the age of 21, living with the client/patient and/or for whom the client/patient is primary care giver. (Do not include children who have been placed by DCFS, temporarily or permanently with others for their care, whether relatives or other foster care.)

Number of Children Age 25 and Under

Count children for whom the client has ever had legal custody or has ever been legally responsible. Include adopted children, stepchildren and deceased children.

Number of Children Living with Someone Else Due to a Child Protection Court Order

Children living with someone else due to a formal order by a court or child protection agency describing where and under whose supervision the child will be living or staying.

Number of Children for Whom Patient/Client Lost Parental Rights

This number should include all children for whom parental rights have been revoked by a formal court order (not voluntary surrender). If a client voluntarily gives up his/her child for adoption, it is not counted here.

Pregnant at Assessment

Indicates if the client/patient is pregnant at the time of the assessment. Enter 'Y' - Yes or 'N' - No.

Living Arrangement (NOMs)

Describes the current living arrangement.

A - Shelter (Safe Havens, Transitional Living Centers (TLC), Low Demand Facilities, Reception Centers, other Temporary Day, or Evening Facilities)
B - Street/Outdoors - (Sidewalk, Doorway, Park, Public or Abandoned Building)
C - Institutional - (Hospital, Nursing Home, Jail/Prison)
D - Owned or Rented Apartment, Room, or House
E - Someone Else's Apartment, Room or House
F - Dormitory/College Residence
G - Halfway House
H - Residential Treatment
I - Recovery Home
J - Other Housed

If the opening date is before 7/1/11, the following FY 2011 codes are used:

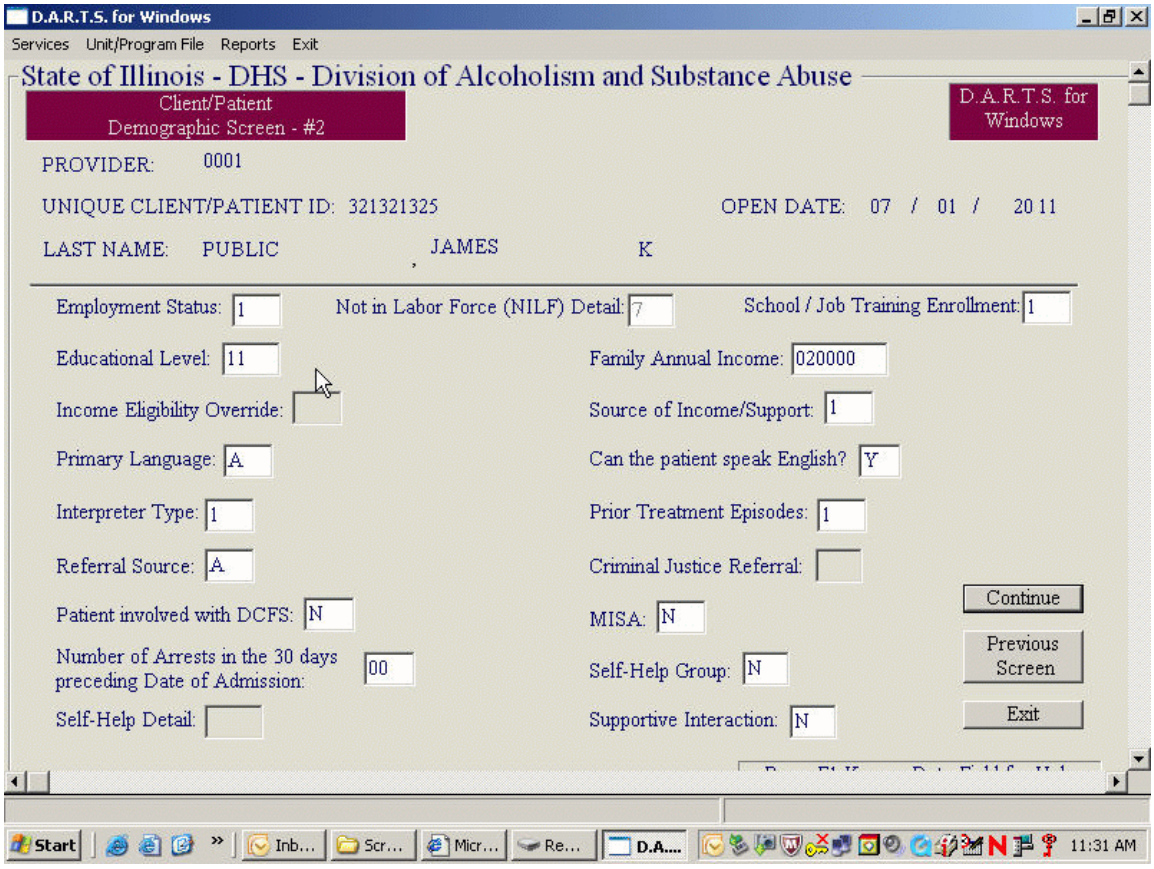
1 - Independent Living
2 - Dependent Living
3 - Homeless

Health Insurance

Identifies the primary insurance carrier or the primary coverage of the parent or guardian if the client/patient is carried as a dependent on that policy.

1 - Private (Other than Blue Cross/Blue Shield or an HMO)
2 - Blue Cross/Blue Shield
3 - Medicare
4 - Medicaid
5 - Health Maintenance Organization (HMO)
6 - Other
7 - None

DEMOGRAPHIC SCREEN 2



Employment Status (NOMs)

Describes the current employment status.

1 - Full-time (working 35 hours or more each week; includes members of the uniformed services)
2 - Part-time (working fewer than 35 hours each week)
3 - Unemployed (looking for work in the past 30 days or on layoff from a job)
4 - Not in Labor Force (NILF) (not looking for work in the last 30 days or homemaker, student, disabled, retired or an inmate of an institution)

Not in Labor Force (NILF) Detail (NOMs)

This field is required when the "Employment Status" = '4' - Not in Labor Force.

1 - Homemaker
2 - Student
3 - Retired
4 - Disabled
5 - Inmate of Institution
6 - Other
7 - Not Applicable
8 - Volunteer Work
9 - Not Looking for Work

School/Job Training Enrollment

For incarcerated persons, this field must be "Not Enrolled"

1 - Not Enrolled
2 - Enrolled, Full Time
3 - Enrolled, Part Time

Educational Level (NOMs)

The highest school grade level completed. Enter "12" for a GED.

Family Annual Income

Enter all projected gross income per calendar year. A total family annual income eligibility criterion is utilized to determine the appropriateness of DASA contract dollars to pay for addiction early intervention or treatment as follows:

FAMILY INCOME ELIGIBILITY CRITERIA
CONTRACT REIMBURSED (NON-MEDICAID)

FY 2014 FAMILY INCOME ELIGIBILITY

Number of Dependents	Annual Income
1	$22,980
2	$31,020
3	$39,060
4	$47,100
5	$55,140
6	$63,180
7	$71,220
8	$79,260

For each additional person, add $8,040.

Income Eligibility Override

This field is required if the client/patient income exceeds the eligibility requirements. Select 1–7 from the following reasons to override the criteria:

1. a dependent adult whose spouse or other responsible party is unwilling to assume financial responsibility for the cost of treatment, and the dependent adult would, as a result, be denied access to treatment services; or
2. a dependent minor who is not Medical Benefits, All Kids and Family Care eligible and/or whose parent(s) or legal guardian is unwilling to assume financial responsibility for the cost of treatment or intervention, and the dependent minor would, as a result, be denied access to treatment or intervention services; or
3. a pregnant woman who is not Medical Benefits, All Kids and Family Care eligible and has no insurance benefit that covers the cost of treatment; or
4. a member of a family unit whose combined debt for prior medical expenses (not covered by insurance) exceeds 7.5% of the total gross family annual income, and the individual would be denied access to treatment due to the unwillingness or inability of the family to assume further debt; or
5. a patient with an extenuating circumstance that meets any additional hardship guidelines adopted by the provider's governing body; or
6. an individual for whom the fee is the sole inhibitor to accept treatment; or
7. other approved governing body criteria.

Source of Income/Support

The primary source of family income.

1 - Wages/Salary
2 - Public Assistance
3 - Retirement/Pension
4 - Disability
6 - None

Primary Language

Specify the primary language spoken by the client/patient.

A - English
B - Arabic
C - Chinese
D - French
E - German
F - Hindi
G - Korean
H - Polish
I - Russian
J - Spanish
K - Urdu
L - Vietnamese
M - Other – Asian
N - Other - African
O - Other - Indian
P - Other

English Proficiency

Indicates if the client/patient can speak English. Enter 'Y' - Yes or 'N' - No.

Interpreter Type

Will interpreter services be needed? Select the type or enter none.

1 - Foreign Language
2 - Hearing Impaired
3 - None

Prior Treatment Episodes of Care

Treatment Episode of Care means the period of service between the beginning of a treatment service (admission) and the termination of services for the prescribed treatment (discharge). Indicate the number of previous treatment episodes the patient has received in any addiction treatment program.

Referral Source

The referral source.

A - **Individual** - Includes the client/patient, a family member, friend, or any other individual who would not be included in any of the following categories.

B - **Addiction Treatment Provider** - Any program, clinic or other health care provider whose principal objective is treating patients with addiction related problems.

C - **Early Intervention Provider** - Any program, clinic or other health care provider whose principal objective is the provision of early intervention services to clients with alcohol or drug related problems.

D - **DHS/SAPP Prevention Provider** - Any program, clinic or other health care provider whose principal objective is the provision of prevention services targeted at preventing alcohol or drug related problems.

E - **Other Health Care Provider** - A physician, psychiatrist or other licensed health care professional, or general hospital, psychiatric hospital, mental health program or nursing home.

F - **School** (Educational) - A school principal, counselor or teacher or a Student Assistance Program, the school system or an educational agency.

G - **Employer/EAP** - A supervisor or an employee counselor.

H - **Other Community Referral** - Community or religious organization or any Federal, State or local agency that provides aid in the areas of poverty relief, shelter, unemployment, or other social services. Self-help groups are included in this category. Defense attorneys are also included in this category.

I - **Criminal Justice Referral** - Any police official, judge, prosecutor, probation officer, or other person affiliated with a federal, state, or county judicial system. Includes referral for DUI and clients referred in lieu of or for deferred prosecution.

J - **Child Welfare (DCFS/POS)** – If the value 'J' is entered as the Referral Source for a client, there must be a 'Y' (Yes) in the field "Patient Involved with DCFS."

Criminal Justice Referral Detail

Required when Referral Source = I - Criminal Justice Referral

1 - State/Federal Court	4 - Other Recognized Legal Entity	7 - DUI
2 - Other Court	5 - Diversionary Program	8 - Other
3 - Probation/Parole	6 - Prison	

DCFS Involved

Identifies if the client/patient is involved with DCFS. Enter 'Y' - Yes or 'N' - No.

Mentally Ill Substance Abuser (MISA)

Identifies if the patient is an individual with a co-occurring substance use disorder and any mental health Axis I or Axis II disorder as identified in the DSM IV. This information can be entered at any time during the treatment or intervention episode and must be diagnosed by a physician or a qualified mental health professional. Enter 'Y' - Yes or 'N' - No.

Answering "Yes" will require that a mental health diagnosis be entered into one of the diagnosis fields.

Number of Arrests in the 30 Days Preceding Date of Admission (NOMs)

Identifies the number of arrests in the 30 days preceding the date of admission.

Social Connectedness (NOMs)

Identifies the client/patient's supportive interaction with family and friends and the level of involvement with self-help groups and other recovery support organizations.

Specify if the client/patient had, in the past 30 days, attended any self-help groups for recovery that were affiliated with a religious or faith-based organization or a peer-operated organization devoted to helping individuals with addiction related problems (i.e., Alcoholic Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety or Women for Sobriety, etc.).

Self-Help Group

Y - Yes N - No R - Refused D - Does Not Know

Self-Help Group Detail

If the answer to the Self-Help Group question is yes, specify how many times or:

RF - Refused
DK - Does Not Know

Specify if the client/patient had, in the past 30 days, interaction with family and/or friends that are supportive of his or her recovery:

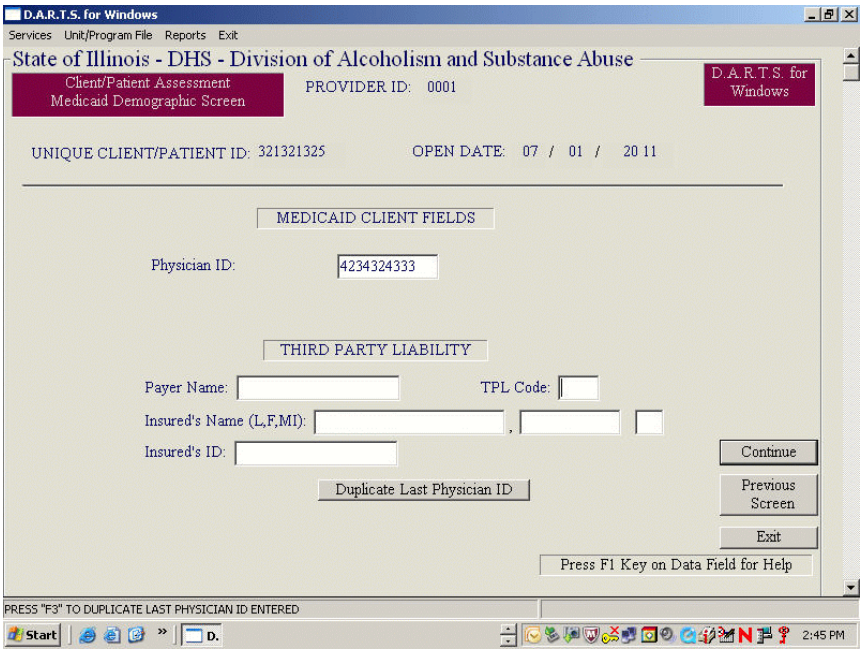
Supportive Interaction

Y - Yes N - No R - Refused D - Does Not Know

MEDICAID DEMOGRAPHIC SCREEN

Completion of these fields is required if Medicaid is the payment source for the service. To avoid service rejections, ensure that the patient is Medicaid eligible on the dates of service prior to billing by:

- **Checking the patient's Medicaid card, or**
- **Calling 1-800-842-1461.**



Attending Physician NPI

The ten-digit all numeric National Provider Identifier (NPI) of the Organization's Medical Director or physician authorized to oversee the patient's treatment episode and other medical procedures.

Third Party Liability (TPL) Information

If APPLICABLE, enter the following fields:

TPL Payer Name

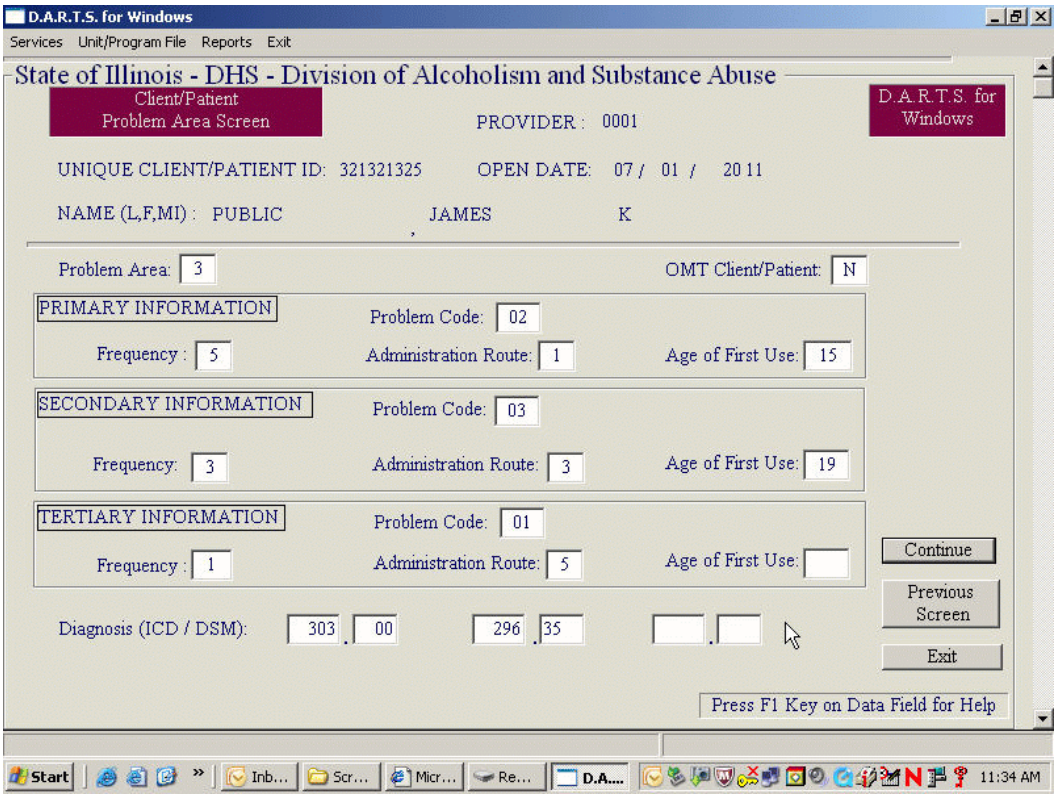
The name of the paying organization from which the provider might expect some payment for treatment service (i.e., private insurance company, Medicare, Medicaid, etc.).

TPL Code
The corresponding Healthcare and Family Services code for the insurance company name.

TPL Insured's Name
The name of the person on the policy.

TPL Insured's ID
The ID of the person on the policy (i.e., insurance company's ID, Medicaid ID, etc.).

DEMOGRAPHIC PROBLEM AREA SCREEN



Problem Area

The area that is the suspected or confirmed major reason that the client/patient requires Intervention or Treatment services.

1 - Alcohol
2 - Drugs
3 - Alcohol and Drugs
4 - Co-Dependence
5 - None
6 - Alcohol/Drugs and Gambling
7 - Gambling

If the Problem Area is #5, indicating "none," the only allowable billing is for assessment. Also, when "none" is selected, the assessment date will default into the discharge date field. The primary, secondary, and tertiary fields of problem code, frequency, and administration routes will be automatically completed.

If the Problem Area is #6 - Alcohol/Drugs and Gambling, the problem code must be alcohol or drugs. One of the diagnosis codes must indicate an alcohol or drug-related problem and the gambling diagnostic code must be 312.31 or 312.30.

If the Problem Area is #7 - Gambling, the diagnosis code must be 312.31 or 312.30 and the primary, secondary, and tertiary fields of problem code, frequency and administration routes will be automatically completed.

Opioid Maintenance Therapy (OMT)

Identifies whether the use of Methadone or Buprenorphine is part of the patient's treatment at the provider's agency. If the patient is not an OMT patient at admission, but becomes one during the course of treatment, the provider should update this field. Enter 'Y' - Yes or 'N' - No.

Primary Problem Code (NOMs)

This field provides additional information relative to the identified "Problem Area" field. For early intervention clients, this field identifies the area that precipitated the need for the early intervention service. NOTE: "01 - None" may only be selected as the primary code if "None" is selected in the "Problem Area" field.

01 - None
02 - Alcohol
03 - Cocaine/Crack
04 - Marijuana/Hashish - includes THC and any other Cannabis Sativa preparations
05 - Heroin
06 - Non-Prescription Methadone
07 - Other Opiates and Synthetics - includes codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, Tramadol and any other drug with morphine-like effects
08 - PCP - Phencyclidine
09 - Other Hallucinogens - Includes LSD, DMT, STP, Hallucingoens, Mescaline, Peyote, Psilocybin, etc.
10 - Methamphetamine
11 - Other Amphetamines - Includes Amphetamines, Phenmetrazine and other unspecified amines
12 - Other Stimulants - Includes Methylphenidate and any other stimulants
13 - Benzodiazepines - Includes Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Flunitrazapam, Flurazepam, Halazepam, Lorazepam, Oxazepam, Prazepam, Temazepam,Triazolam
14 - Other Non-Benzodiazepan Tranquilizers - Includes Meprobamate, Tranquilizers, etc.
15 - Barbiturates - Includes Amobarbital, Pentobarbital, Phenobarbital, Secobarbital, etc.
16 - Other Non-Barbiturate Sedatives or Hypnotics - Includes Chloral Hydrate, Ethchlorvynol, Glutethimide, Methaqualone, etc.
17 - Inhalants - Includes chloroform, ether, gasoline, glue, nitrous oxide, paint thinner, etc.
18 - Over-the-Counter - Includes aspirin, cough syrup, Diphenhydramine and other antihistamines, sleep aids and any other legally obtained non-prescription medication.
19 - Nicotine (Only available to use as a secondary or tertiary choice)
20 - Other - Includes Diphenylhydantoin/Phenytoin, GHB/GBL, Ketamine
21 - Gambling
22 - Ecstasy
23 - Rohypnol
24 - Steroids
25 - Ephedrine/Psuedoephedrine

Primary Frequency (NOMs)

1 - 0 within one month prior to admission
2 - 1–3 times in the past month
3 - 1–2 times in the past week
4 - 3–6 times per week
5 - Daily

Primary Administration Route

1 - Oral
2 - Smoking
3 - Inhalation
4 - Injection IV or intramuscular
5 - Not Applicable

Primary Age of First Use

For drugs, this field identifies the age at which the client/patient first used the identified drug. For alcohol, this field records the age of first intoxication for treatment patients. For early intervention clients and patients with gambling as a primary diagnosis, this field is not required.

Secondary Problem Code (NOMs), Frequency (NOMs), Administration Route and Age of First Use

The same code choices as those designated under primary. If there is no secondary problem code, do not complete these fields.

Tertiary Problem Code (NOMs), Frequency (NOMs), Administration Route and Age of First Use

The same code choices as those designated under primary. If there is no tertiary problem code, do not complete these fields.

Diagnosis

No entry will be made in this field for early intervention clients. For treatment patients, an entry must be made in at least one field and an alcohol or drug abuse/dependence diagnosis is required as one of these fields unless Problem Area #4, #5 or #7 is selected. The diagnosis code must be a valid DSM-IV or ICD-9 code.

If Problem Area #4 - (Co-Dependence) is selected, the diagnosis code must be **"V61.9"** will be automatically entered by DARTS and only PEV, Level I and CM can be entered.

If Problem Area #5 - (None) is selected, the diagnosis code **"V71.09"** will be automatically entered in DARTS.

If Problem Area #7 - (Gambling) is selected, the diagnosis must be 312.30 or 312.31.

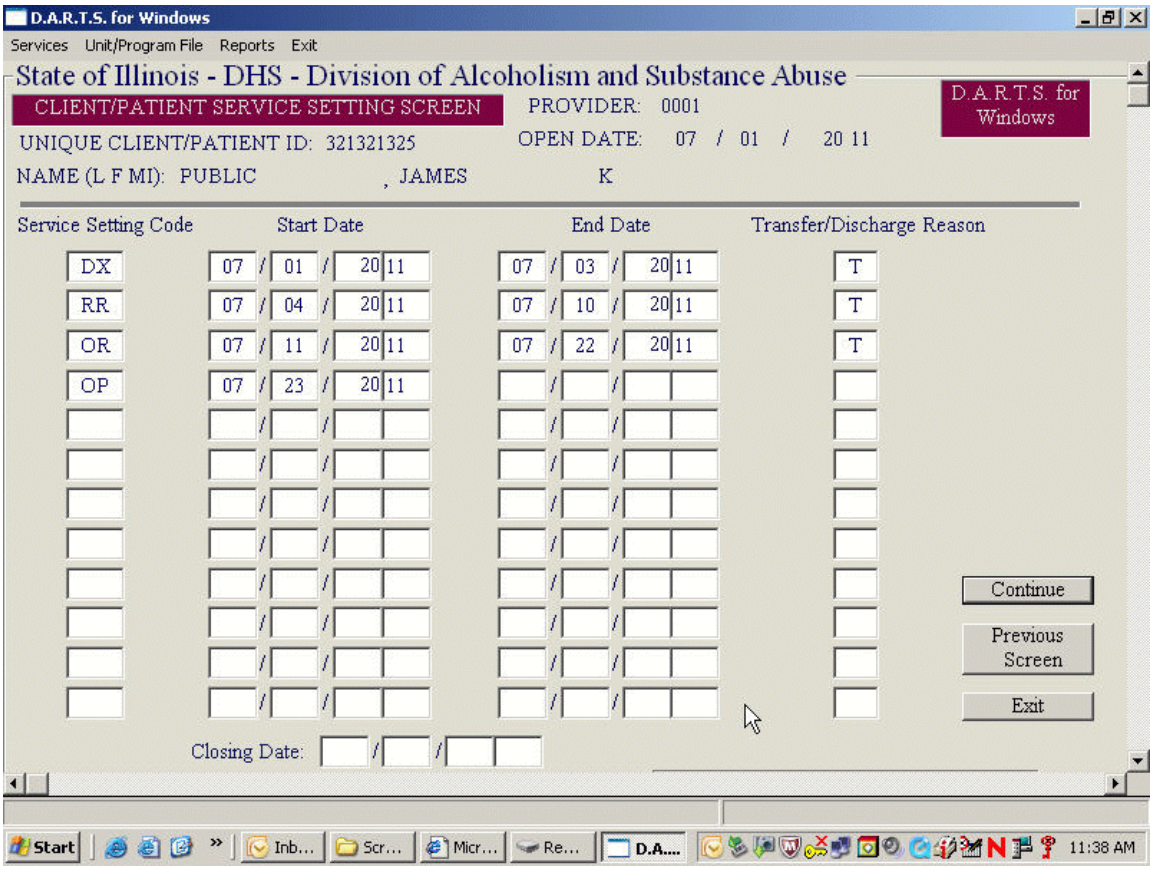
Use of the second field and third fields are optional unless the patient is identified as MISA, in which case at least one of the diagnosis fields must contain a mental health diagnosis, or unless Problem Area #6 - Alcohol/Drugs and Gambling is selected in which case at least one of the diagnosis fields must contain the diagnostic code 312.31 or 312.30.

DISCHARGE: How is a Client/Patient Closed from DARTS?

Demographics required for discharge are collected on the "Client/Patient Discharge" data input form. The information contained on this form is then used to input the data into DARTS. Discharge in DARTS is critical to reduce the incidence of submission errors and to ensure correct reporting of national outcome measures. Discharge means the termination of all services for the prescribed intervention or treatment by some action initiated by the organization and/or the client/patient. Any change in service within the same Provider during an episode of care is considered a discharge with a transfer code selected as the reason. The prescribed intervention/treatment should be assumed to have ended if the client/patient has not received a service in three days in the case of residential services and 30 days in the case of intervention or outpatient services. All discharge questions should be completed relative to the client/patient's condition **at last known contact** and submitted to DASA. Billing for a discharge assessment is not allowed unless the client/patient is discharged in DARTS through completion and submission of information required on the following screens. When a

discharge reason is entered on the Client/Patient Service Setting Screen, this then requires completion of the Client/Patient Discharge Outcome Measures Screen.

CLIENT/PATIENT SERVICE SETTING SCREEN



(See examples of corresponding “Client/Patient Discharge Outcome Measures” screens in the next section on pages 21 and 22)

Service Setting Code

The two-digit code established by DASA to identify the service the client/patient is receiving.

OP - Level I (Outpatient)
OR - Level II (Intensive Outpatient)
HH - Level III.1 (Residential Extended Care)
RR - Level III.5 (Residential Rehabilitation)
DX - Level III.2D/III.7D (Detoxification)
RH - Recovery Home

Start Date

The date of admission into the specified service setting code.

End Date

The date of discharge from the specified setting code.

Transfer/Discharge Reason (NOMs)

This code was established by DASA to identify the reason for the transfer/discharge as follows:

A - Assessment resulted in a finding of "none" in the problem area field contained within the demographic record. When "none" is entered into this field, the only allowable billing is for an assessment for admission.

B - Completion of Intervention or Treatment services. This code is used to indicate completion of all planned treatment for the current episode of care. Completion of treatment at one level of care within the same provider is not "completion of treatment" if there is additional treatment planned as part of the treatment episode. When this occurs, a discharge reason indicating transfer code should be selected.

C - Left against staff advice. This code should be selected when the client/patient chose not to complete services, with or without specific advice to continue. This includes clients/patients who "drop out" of intervention or treatment for unknown reasons and those who have not received services in three days following completion of residential services and 30 days for outpatient. DASA also uses this code every month to close old admission records at DASA that have not had any service in over six months.

D - Terminated by facility. This code is used when services are terminated by action of the provider, generally because of client/patient noncompliance or violation of rules, laws or procedures (not because client/patient dropped out of treatment, was incarcerated or some other client/patient motivated reason).

F - Incarcerated. This code is to be used for all clients/patients whose intervention or treatment is terminated due to incarceration through jail, prison, or house confinement.

G - Death.

H - Discharged to another Provider. Utilization Management decision.

I - External Transfer to another Provider. Non-completion of the current level of care treatment plan, transferred to another provider.

J - External Transfer to another Provider. Completion of the current level of care treatment plan, transferred to another provider.

T - Internal Transfer within the same Provider. Completion of the current level of care treatment plan, transferred to a different level of care.

U - Internal Transfer within the same Provider. Non-completion of the current level of care treatment plan, transferred to a different level of care.

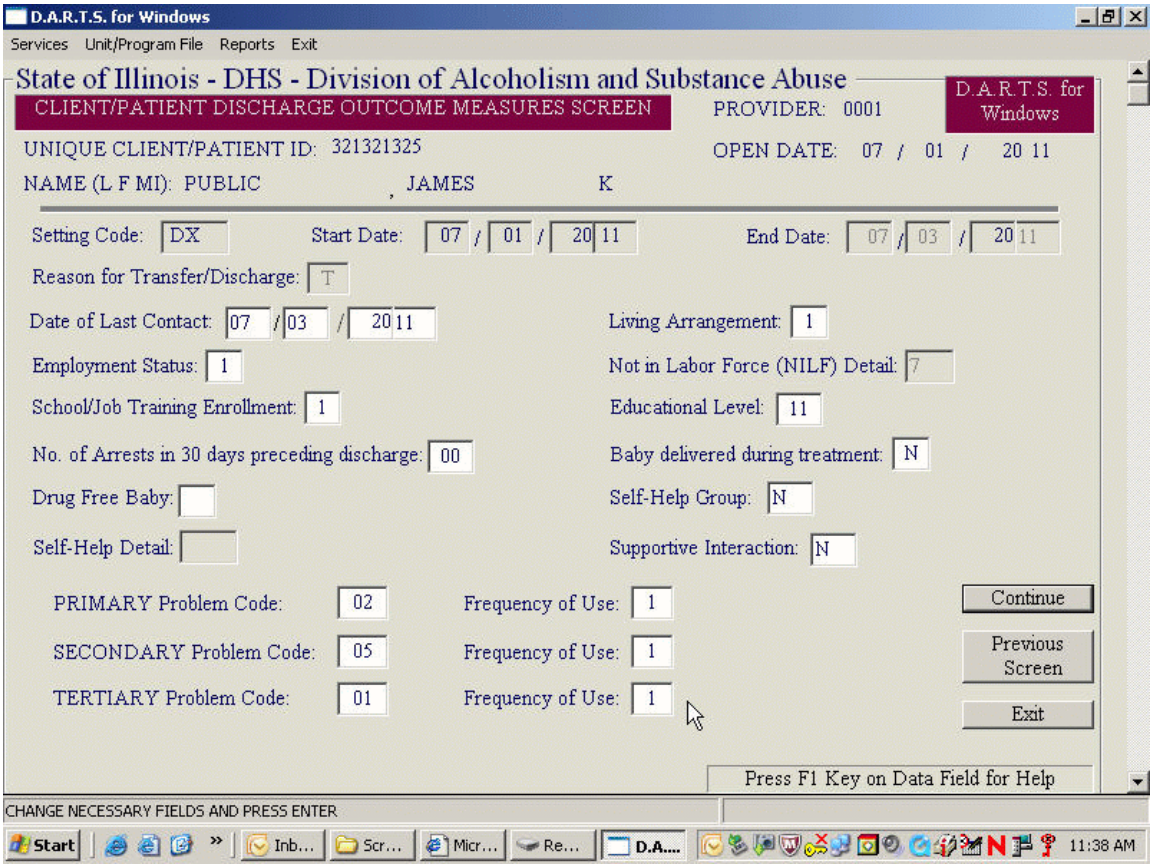
V - Internal Transfer within the same Provider. Transferred to another level of care. Utilization Management decision.

Closing Date

The last date of service for the **episode of care**. For billing purposes, this is the last date that a service can be billed. Any bill submitted with a date after that of the closing date will be rejected as an error.

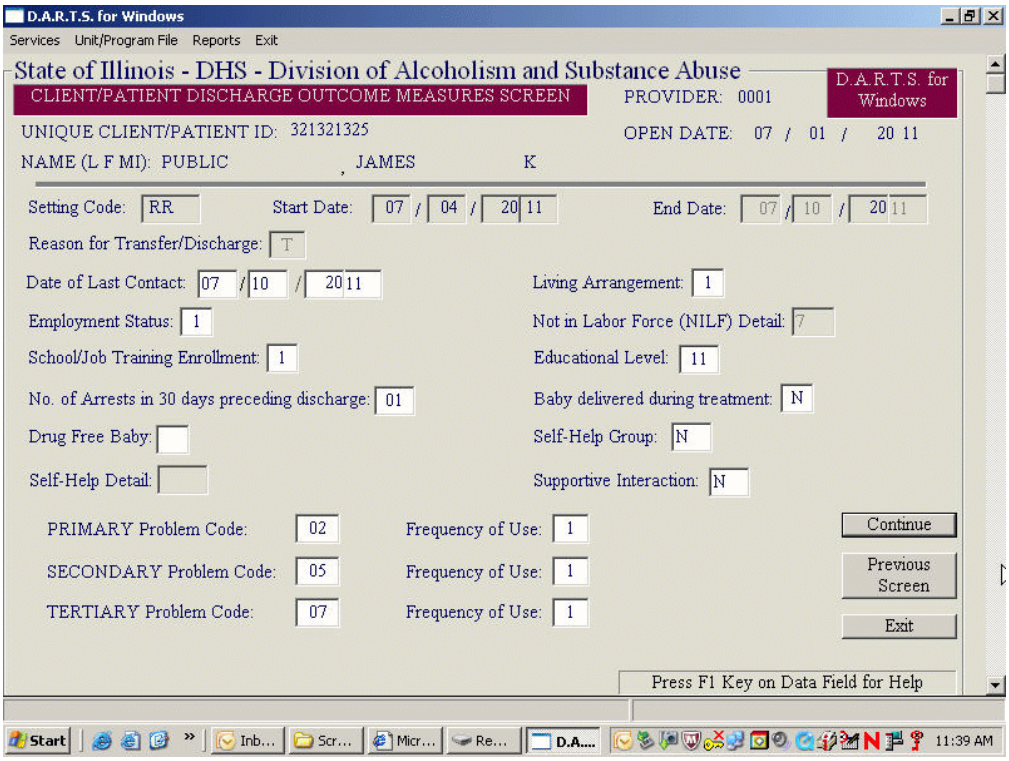
CLIENT/PATIENT DISCHARGE OUTCOME MEASURES SCREEN

The following three examples of Discharge Screens are for the Example Discharges on the "Client/Patient Service Setting Screen" on page 19 of this manual. The examples demonstrate how the collection of outcomes should be documented for each service setting code.

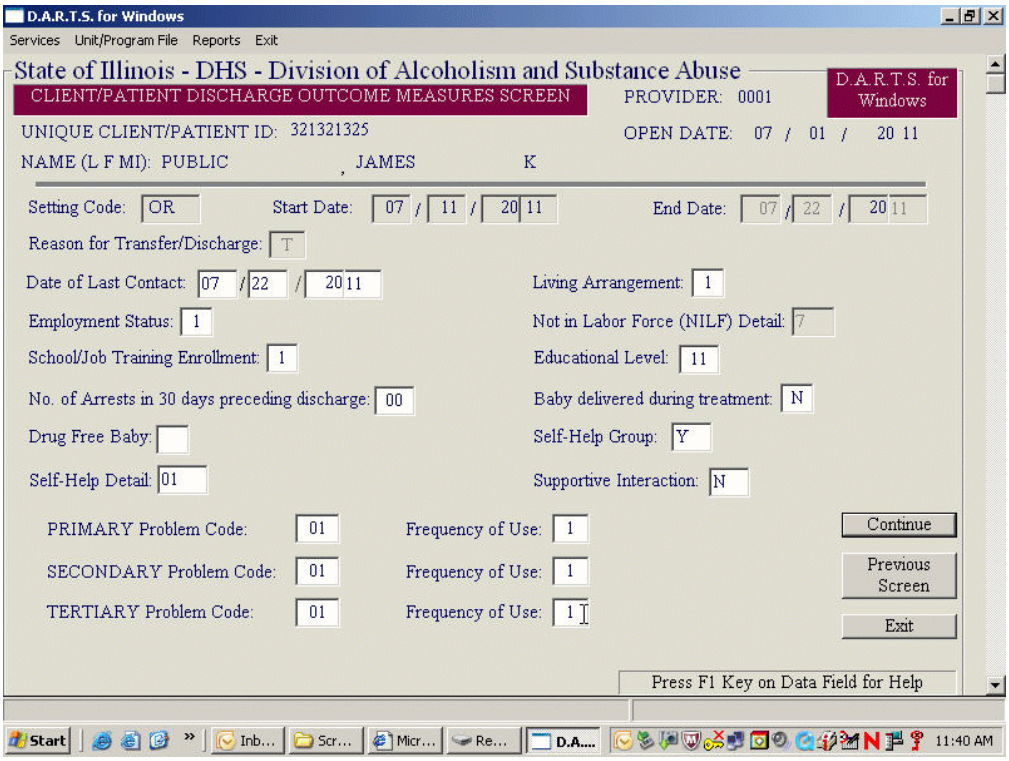


Example 1: Discharge Screen for Detox Service Setting Code

Example 2: Discharge Screen for Level III Service Setting Code



Example 3: Discharge Screen for Level II Service Setting Code



Date of Last Contact (NOMs)

The date of the last contact with the client/patient even if this date is the same as the discharge date.

Living Arrangement (NOMs)

Identifies the current living arrangement at the time of discharge.

A - Shelter (Safe Havens, Transitional Living Center (TLC), Low Demand Facilities, Reception Centers, other Temporary Day or Evening Facilities)
B - Street/Outdoors (Sidewalk, Doorway, Park, Public or Abandoned Building)
C - Institution (Hospital, Nursing Home, Jail/Prison)
D - Owned or Rented Apartment, Room or House
E - Someone Else's Apartment, Room or House
F - Dormitory/College Residence
G - Halfway House
H - Residential Treatment
I - Recovery Home
J - Other Housed

If the Transfer/Discharge Date (End Date) is before 7/1/11, the following FY 2011 codes are used:

1 - Independent Living
2 - Dependent Living
3 - Homeless

Employment Status (NOMs)

Describes the current employment status at the time of discharge.

1 - Full-time (working 35 hours or more each week; includes members of the uniformed services)
2 - Part-time (working fewer than 35 hours each week)
3 - Unemployed (looking for work in the past 30 days or on layoff from a job)
4 - Not in Labor Force (NILF) (not looking for work in the last 30 days or homemaker, student, disabled, retired or an inmate of an institution)

Not in Labor Force (NILF) Detail (NOMs)

This field is required when "Employment Status at the time of discharge" = '4' (Not in Labor Force).

1 - Homemaker
2 - Student
3 - Retired
4 - Disabled
5 - Inmate of Institution
6 - Other
7 - Not Applicable
8 - Volunteer Work
9 - Not Looking for Work

School/Job Training Enrollment

For incarcerated persons, this field must be "Not Enrolled"

1 - Not Enrolled
2 - Enrolled, Full Time
3 - Enrolled, Part Time

Educational Level (NOMs)

The highest school grade level completed at the time of discharge. Enter "12" for a GED.

Number of Arrests in the 30 Days Preceding the Date of Discharge (NOMs)
The number of times, if any, that the client/patient has been arrested in the thirty days preceding the date of discharge.

Baby Delivered During Treatment (NOMs)
Indicates if the client/patient delivered a baby while receiving treatment. If yes, indicate if the baby was drug free.

Social Connectedness (NOMs)
Identifies the client/patient's supportive interaction with family and friends and the level of involvement with self-help groups and other recovery support organizations at the time of discharge.

Specify if the client/patient had, in the past 30 days, attended any self-help groups for recovery that were affiliated with a religious or faith-based organization or a peer-operated organization devoted to helping individuals with addiction related problems (i.e., Alcoholic Anonymous, Narcotics Anonymous, Oxford House, Secular Organization for Sobriety or Women for Sobriety, etc.).

Self-Help Group

Y - Yes
N - No
R - Refused
D - Does Not Know

Self-Help Group Detail

If the answer to the Self-Help Group question is yes, specify how many times or:

RF - Refused
DK - Does Not Know

Specify if the client/patient had, in the past 30 days, interaction with family and/or friends that are supportive of his or her recovery:

Supportive Interaction

Y - Yes
N - No
R - Refused
D - Does Not Know

Primary Problem Code (NOMs)
This field provides additional information relative to the identified "Problem Area" field at the time of discharge.

01 - None
02 - Alcohol
03 - Cocaine/Crack
04 - Marijuana/Hashish - includes THC and any other Cannabis Sativa preparations
05 - Heroin
06 - Non-Prescription Methadone

07 - Other Opiates and Synthetics - includes codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, Tramadol and any other drug with Morphine-like effects.
08 - PCP - Phencyclidine
09 - Other Hallucinogens - Includes LSD, DMT, STP, Hallucingoens, Mescaline, Peyote, Psilocybin, etc.
10 - Methamphetamine
11 - Other Amphetamines - Includes Amphetamines, Phenmetrazine, and other unspecified amines
12 - Other Stimulants - Includes Methylphenidate and any other stimulants
13 - Benzodiazepines - Includes Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate, Diazepam, Flunitrazapam, Flurazepam, Halazepam, Lorazepam, Oxazepam, Prazepam, Temazepam,Triazolam
14 - Other Non-Benzodiazepan Tranquilizers - Includes Meprobamate, Tranquilizers, etc.
15 - Barbiturates - Includes Amobarbital, Pentobarbital, Phenobarbital, Secobarbital, etc.
16 - Other Non-Barbiturate Sedatives or Hypnotics - Includes Chloral Hydrate, Ethchlorvynol, Glutethimide, Methaqualone, etc.
17 - Inhalants - Includes chloroform, ether, gasoline, glue, nitrous oxide, paint thinner, etc.
18 - Over-the-Counter - Includes Aspirin, cough syrup, Diphenhydramine and other antihistamines, sleep aids and any other legally obtained non-prescription medication.
19 - Nicotine (Only available to use as a secondary or tertiary choice)
20 - Other - Includes Diphenylhydantoin/Phenytoin, GHB/GBL, Ketamine
21 - Gambling
22 - Ecstasy
23 - Rohypnol
24 - Steroids
25 - Ephedrine/Psuedoephedrine

Primary Frequency (NOMs)

1 - 0 within one month prior to discharge
2 - 1–3 times in the past month
3 - 1–2 times in the past week
4 - 3–6 times per week
5 - Daily

Secondary Problem Code (NOMs)

The same code choices as those designated under primary. If there is no secondary problem code, do not complete these fields.

Tertiary Problem Code (NOMs)

The same code choices as those designated under primary. If there is no tertiary problem code, do not complete these fields.

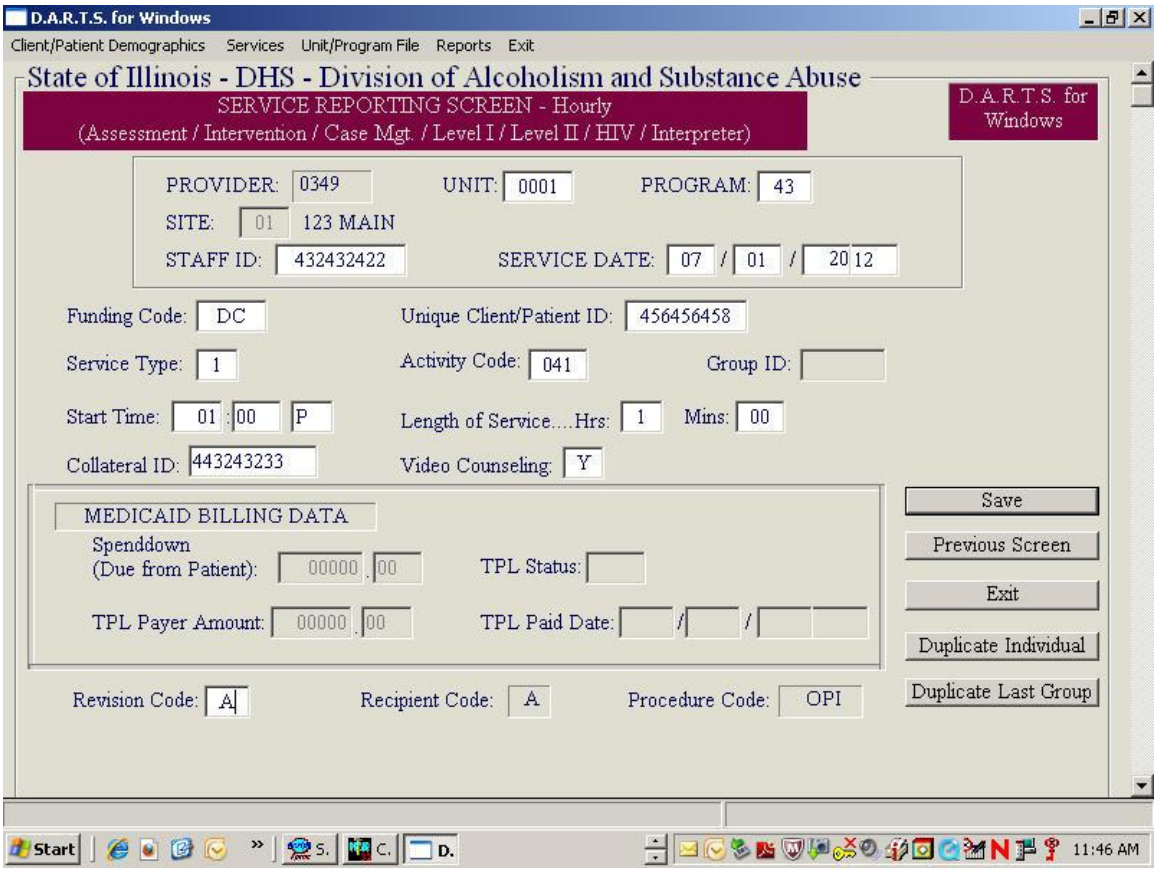
How Do I Enter Delivered Services into DARTS?

Service delivery information is collected and recorded on DARTS data input forms. The information contained on these forms is then used to input data into DARTS through the Service Reporting Menu, which contains three sections for data entry. To enter services, choose "Service" from the main menu bar. The following screen will be displayed.

What Types of Services Can Be Entered?

Services are entered onto specific data entry screens that relate to how the service paid, either hourly, per event or per diem. The hourly services that can be reported are Assessment, Early Intervention, Community Intervention, Level I, II Individual and Group Counseling, Case Management, HIV Counseling and Testing and Interpreter Referral services. These services are paid with an hourly rate that can be reported in quarter hour increments.

SERVICE REPORTING SCREEN - HOURLY



The following fields are required for completion of this screen.

Unit/Program

The valid unit and program number for the service that is reported. Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year-to-year. All addresses should match those specified on DASA facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify DASA immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Site Number

This field is required **ONLY** for billing of Assessment, Case Management, Early Intervention or Community Intervention at more than one site.

Staff ID

The unique nine-digit identification number for the staff member providing services.

Service Date

The date of service.

Funding Code

The funding code is what directs DARTS to the correct payment source for the service. The following codes are used:

DC - DARTS/Contract: A Service, which is supported in full or in part by DASA CONTRACT (Non-Medicaid) funding

DM - DARTS/Medicaid: A Service, which is supported in full or in part by DASA MEDICAID funding. Services linked to a DM code are processed and forwarded on to the Department of Healthcare and Family Services (HFS) for reimbursement. HFS produces the Medicaid Remittance Report.

Unique Client/Patient Identifier

The 9-digit Unique Client/Patient Identifier must match the demographic record for the client/patient.

Service Type

There are three service types that can be used to report services that are paid hourly:

1. **Individual**
2. **Group Service**
3. **Support (Includes Case Management, Community Intervention, HIV Counseling and Testing Activity, HIV Early Intervention Training and Interpreter Referral, Donated Funds Initiative (DFI))**

Activity Code

Activity codes are **mandatory** and are used for identification of specific types of activity that relate to a general service. The activity code is three digits comprised of the specific type of service activity that was performed and the location as follows:

Location Codes

0 - Service at Provider Location
1 - Off Site

Assessment (Only allowed for use with Program Number "48")

70 - Admission
71 - Discharge
72 - Gambling Assessment (only for use by providers with specific funding for gambling services)

Assessment should be used only for diagnosis and assessment of the six (6) ASAM dimensions in order to place the patient into a level of care.

Treatment or Early Intervention Service (Only allowed for use with Program Number "42", "43" and "44")

01 - Individual Counseling

02 - Counseling Group
04 - Continued Stay Review and Discharge Planning
05 - Treatment Planning
06 - Didactic Group
07 - Recreation
08 - Telephonic

Psychiatric Review

11 - Psychiatric Evaluation
12 - Medication Monitoring

Case Management (Only allowed for use with Program Number "41")

22 - Intra-Agency Staffings
23 - Case Coordination

Case management services can be bundled and reported in larger increments of time. For example, a treatment patient's case is staffed 10 minutes each day on 24 different days during one month. These minutes can be bundled into hour increments and reported once as four hours of case management. Services should be bundled by staff ID linked to each patient ID and the date of service entered into DARTS should be the last date of service in the bundle.

Community Intervention (CIH) (Only allowed for use with Program Number "42" and a Service Type of "3")

31 - In-reach
32 - Out-reach
33 - Case Finding
34 - Crisis Intervention
35 - Training (Can only be used by providers who are specifically funded to deliver or obtain training and to report such training to DARTS)
37 - Client/Patient Transportation

Community Intervention can be bundled and reported in larger increments of time. Services should be bundled by staff ID and the date of service entered into DARTS should be the last date of service in the bundle.

Collateral (Only allowed for use with Program Number "42", "43" and "44" with a Service Type of "1" or "2")

41 - Family or Significant Other
42 - Other (Employer, Friend, Minister, etc.)

HIV Early Intervention (Only allowed for use with program number "95")

51 - Test Decision - Initial Session
52 - Test Decision - Follow-up Session
53 - Post-test Session
54 - Community Intervention
55 - Case Management
56 - Phlebotomy Tracking

57 - HIV C and T Training
58 - Semiannual Training

HIV Early Intervention Training - (Only allowed for use with program number "96." For use only by providers who are specifically funded to deliver HIV early intervention training and to report such training to DARTS.)

59 - Administration
60 - Workshop Delivery and Support
61 - Training Evaluation

Interpreter Referral - (Only allowed for use with program number "64")

62 - Interpreter Referral Services

Gambling - (Only allowed for use by providers with funded gambling services. Patient type must be "T", using program number "43", Service Type 2, with an "L" dedicated funding tag and a problem area of 1, 2 or 3.)

63 - Gambling

Donated Funds Initiative (DFI) - Use the hours field to enter the number of tokens. Numbers must be 1 through 9. (Only allowed for use with Program Number "49" and service type "3")

66 - Case Management
67 - Round Trip Public Transportation
68 - One Way Trip Public Transportation
69 - Staff Transportation

(Round trip or One Way Public Transportation can be bundled up to 9 tokens in the hour field)

Procedure Code

This field is <u>not</u> entered by the user. When the date, unit/program, funding code and service type are entered, DARTS will check to assure that the user has been funded for the type of service entered and will automatically enter the procedure code. Procedure codes with their associated funding codes are as follows:

Funding Code "DM" or "DC":

AAS - Assessment
OPI - Outpatient Individual
IOI - Intensive Outpatient Individual
OPG - Outpatient Group
IOG - Intensive Outpatient Group
PEV - Psychiatric Evaluation

Funding Code "DC" Only:

EII - Intervention Individual
EIG - Intervention Group
CMH - Case Management
CIH - Community Intervention
HIV - HIV Service
INT - Interpreter Referral
DFC - DFI Case Management
DFF - DFI Round Trip Public Transportation

DFH - DFI One Way Trip Public Transportation
DFS - DFI Staff Transportation

Group ID

The group ID should be a unique five-digit combination of numbers and/or letters that will distinguish the treatment counseling group from other such groups on the same date of service. This Group ID is used by DASA for auditing purposes to determine the number of patients per counseling group. DASA will only reimburse for up to 16 patients (Medicaid or Contract funds) per counseling group.

Start Time

The time of day in which the service began, including 'A' for AM, or 'P' for PM.

Length of Service

Hours of Service:

The number of hours the service was provided. Hours must be entered as whole numbers.

(For DFI, use this field to enter the number of transportation tokens.)

Minutes of Service:

Minutes of service should be rounded to the nearest quarter-hour increment based upon the actual number of minutes of delivered service (i.e., 1 hour, 45 minutes; 30 minutes; etc.). This field may be left blank, if there were "00" minutes.

EXAMPLES OF ROUNDING

11 minutes = Rounded 15 minutes	34 minutes = Rounded 30 minutes
20 minutes = Rounded 15 minutes	40 minutes = Rounded 45 minutes
29 minutes = Rounded 30 minutes	52 minutes = Rounded 45 minutes

Collateral ID

When an activity code of 041 or 141, the collateral is a family member or significant other, a unique identifier shall be entered. There must be a demographic record in DARTS for client/patient in order to serve a collateral.

Video Counseling

Was this service delivered via video counseling? Enter 'Y' - Yes or 'N' - No.

For program numbers '42' (Early Intervention), '43' (Level I) and '44' (Level II), the following Activity Codes allowed for video counseling services:

01 - Individual
02 - Counseling Group
04 - Continued Stay Review and Discharge Planning
05 - Treatment Planning
06 - Didactic Group
11 - Psychiatric Evaluation
12 - Medication Monitoring
41 - Collateral – Family/Significant other
42 - Collateral – Other (Employer, friend, minister, etc.)

63 - Gambling
70 - Admission Assessment
71 - Discharge Assessment
72 - Gambling Assessment

(The Funding Code must be "DC" (DARTS Contract) – except for Activity code "11" (Psych Eval., which can be "DM" or "DC").

Medicaid Spend Down (Due from Patient)

The amount that the patient is responsible for before Medicaid Eligibility can be established. If not applicable, leave this field blank.

Third Party Liability (TPL) Information

If applicable, enter the following fields:

TPL Status - Enter the adjudication status of the amount in question:

01 - TPL adjudicated - total payment shown
02 - TPL adjudicated - patient not covered
03 - TPL adjudicated - services not covered
05 - Patient not covered
06 - Services not covered
07 - Billed insurance/not paid

TPL Payer Amount - Enter the amount of payment received from the third party health resource or the patient.

TPL Paid Date - If the status is **01**, **02**, or **03** - enter the Third Party Adjudication Date. If the STATUS is **05**, **06**, or **07** - enter the service.

NOTE: If the TPL Information is entered on any Service Screen, the admission record for this patient must have completed all TPL demographic information.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted by DASA.
Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted by DASA. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by DASA.

Only for use with funding code "DC." This code voids a record that was submitted **and** accepted by DASA. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made by DASA and the void can be made to the record.

Dedicated Funding Category Window (Non-Medicaid)

Dedicated funding is contained in many DASA contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations regardless of whether such funding is contained in a global cost center. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of "DC" or "DS" can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

D - DCFS
G - OMT Toxicology
L - Gambling
N - None

Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding but the service being reported does not apply to the patient, select "N" for none. It is very important that dedicated funding is reported correctly. This is how DASA measures compliance with the contract and these amounts are reflected on special dedicated funding reports.

What are Some Examples of Types of Hourly Services and How They Would Be Entered?

The following information provides some examples of specific combinations of client/patient types, program number, service type, procedure, and activity codes and may be helpful in determining how to enter services:

Assessment

The assessment is a distinctly reported and separately billed service and the assessment date is entered in the demographic record.

- The client/patient receives an assessment and is recommended for a treatment service. (Client/Patient Type is "T," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070)
- The client/patient receives an assessment and is recommended for an early intervention service. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070)
- The client/patient receives an assessment and is not recommended for any service. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 070) A closing for the demographic record is also completed and submitted.

Early Intervention - Individual or Group (Client/Patient Type - "I")

- The client meets with a staff member for an individual session to discuss the content and structure of the early intervention services that the client will receive. (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 001)
- A staff member meets with the parents of an adolescent who is receiving early intervention services. (Program Number - 42, Service Type - 1, Procedure Code - EIG, Activity Code - 041)

- The client participates in a group didactic session. (Program Number - 42, Service Type - 2, Procedure Code - EIG, Activity Code - 006)
- The client is participating in an individual session because of a Moderate Risk classification resulting from an arrest for Driving Under the Influence of Alcohol or Other Drugs (DUI). (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 001)
- The client participates in a recreational activity. (Program Number - 42, Service Type - 2, Procedure Code - EIG, Activity Code - 007)
- The client meets with a physician for medication monitoring. (Program Number - 42, Service Type - 1, Procedure Code - EII, Activity Code - 012)

Community Intervention – (Client/Patient Type - "I")

- A meeting is held with a group of local DHS office workers to discuss screenings and referrals for addiction related services. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 031)
- A meeting is held with a group of high school teachers and administrators to discuss how to intervene with and refer students who are caught with alcohol or other drugs as school. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 032)
- A staff member speaks with a person on the phone who is unsure if they have an addiction related problem or uncertain if they want to come to the facility and will not schedule an appointment. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 034)
- A meeting is held with an Employee Assistance Coordinator of a local business. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 033)
- A patient is transported to and from the treatment center. (Program Number - 42, Service Type - 3, Procedure Code - CIH, Activity Code - 037)

Outpatient or Intensive Outpatient - Individual or Group - (Client/Patient Type - "T")

- The patient meets with a clinician for an individual counseling session. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 001)
- The patient meets with a clinician for a continued stay review. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 004)
- The patient meets with a physician for medication monitoring. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 012)
- The clinician meets with a family member to discuss a patient's care. (Program Number - 43 or 44, Service Type - 1, Procedure Code - OPI or IOI, Activity Code - 041)
- The patient participates in a counseling group session. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 002)
- The patient participates in a didactic group session. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 006)
- The patient participates in a recreational activity. (Program Number - 43 or 44, Service Type - 2, Procedure Code - OPG or IOG, Activity Code - 007)

Case Management

- A Discussion with other providers regarding supportive services to the patient (e.g., child care, Medicaid needs, public assistance, etc.). (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 023)
- The Provider contacts another staff member within the same organization to discuss the patient's treatment or discharge planning. (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 022)
- The organization has a weekly meeting to staff treatment patients. (Program Number 41, Service Type - 3, Procedure Code - CMH, Activity Code - 022)

Psychiatric Evaluation

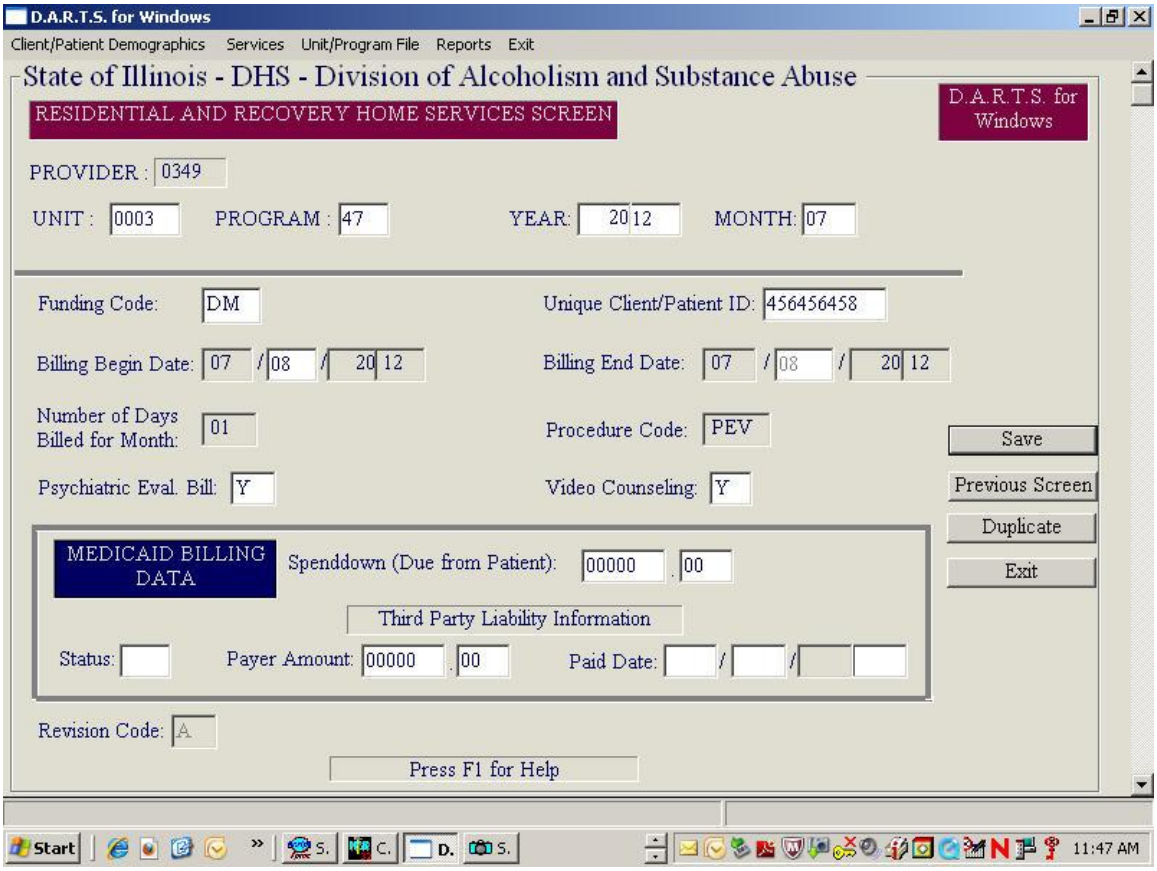
- An early intervention client receives a psychiatric evaluation. (Program Number 42, Service Type - 1, Procedure Code - PEV, Activity Code - 011)
- A treatment client receives a psychiatric evaluation. (Program Number 43 or 44, Service Type - 1, Procedure Code - PEV, Activity Code - 011)

Discharge Assessment

The discharge assessment is a distinctly reported and separately billed service. Billing for a discharge assessment will be rejected unless the client/patient discharge demographic record has been submitted.

- The treatment episode of care has ended for the patient. The demographic record in DARTS is closed and submitted and a discharge assessment is reported. (Client/Patient Type is "T," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 071).
- The early intervention episode of care has ended for the client. The demographic record in DARTS is closed and submitted and a discharge assessment is reported. (Client/Patient Type is "I," Program Number - 48, Service Type - 1, Procedure Code - AAS, Activity Code - 071).

SERVICE REPORTING SCREEN: RESIDENTIAL AND RECOVERY HOME SERVICES



The Residential and Recovery Home Services screen is where all Level III and Recovery Home services reimbursed per diem are reported. Additionally, psychiatric evaluations for patients receiving these services can also be reported on this screen and are reimbursed per event. The following fields are required for completion of this screen.

Unit/Program

The unit and program number of the service that is reported. Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year to year. All addresses should match those specified on DASA facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify DASA immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Year, Month

The year and month of the service.

Funding Code

The funding code is what directs DARTS to the correct payment source for the service. The following codes are used:

DC - DARTS/Contract: A Service which is supported in full or in part by DASA CONTRACT (Non-Medicaid) funding

DM - DARTS/Medicaid: A Service, which is supported in full or in part by DASA MEDICAID funding. Services linked to a DM code are processed and forwarded on to the Department of Healthcare and Family Services (HFS) for reimbursement. HFS produces the Medicaid Remittance Report.

DS - DARTS/Split Billing: A Service, which is supported, by both CONTRACT AND MEDICAID funding. This funding code is only used to report certain LEVEL III services in which the treatment cost is paid by Medicaid and domiciliary cost is paid by Contract.

Unique Client/Patient Identifier

The 9-digit Patient Unique Client Identifier must match an opening in DARTS.

Billing Begin and End Date

The Billing Begin Date through the Billing End Date reports the time period for which the provider is seeking payment. If billing Medicaid ('DM' or 'DS'), the patient must be eligible for Medicaid during this date. If the patient is not Medicaid eligible for the continuous stay, each continuous segment must be billed separately. (Example: A patient enters a program on the 5th of the month, and he stays through the 25th of that month; however, the patient is NOT Medicaid eligible on the 10th and 11th. Two 'DM' or 'DS' billing records would be created. The first record would be for the 5th through the 9th. The second record would be the 12th through the 25th.)

Additionally, when a Level III or Recovery Home service spans two months, the service must be entered as two separate transactions. Example: There would be two entries for a patient who receives a Level III or Recovery Home service from 07/15/2011 through 08/04/2011. The first would be 07/15/2011 - 07/31/2011, and the second would be 08/01/2011 - 08/04/2011.

Number of Days

This number is automatically computed by the dates entered into the Billing Begin and End Date fields.

Procedure Code

This field is not entered by the user. When the date/unit/program/funding code and billing type are entered, DARTS will check the Unit/Program file to assure that the agency has been funded for the type of service entered and will complete the procedure code automatically.

The following procedure codes (linked to the funding code) are used for **LEVEL III service:**

If the program is **MEDICAID CERTIFIED and ENROLLED** for **DAY TREATMENT or MEDICALLY MONITORED DETOXIFICATION** and also **has other CONTRACT funding**:

Funding Code "DS"	DCY	- Youth Residential Day Treatment (treatment portion of bill paid by Medicaid); **AND**
	RBD	- Residential Domiciliary (room and board portion of bill paid by Contract)
	DCA	- Adult Residential Day Treatment (treatment portion of bill paid by Medicaid); **AND**
	RBD	- Residential Domiciliary (room and board portion of bill paid by Contract)
	DXT	- Medically Monitored Detoxification Treatment (treatment portion of bill paid by Medicaid) **AND**
	DXB	- Medically Monitored Detoxification Domiciliary (room and board portion of bill paid by Contract)

If the program is **MEDICAID CERTIFIED and ENROLLED** for **DAY TREATMENT or MEDICALLY MONITORED DETOXIFICATION**; BUT has no other **CONTRACT funding** or is billed after the final submission date when contract funds for the previous fiscal year can no longer be accessed, the following procedure codes will be used for billing:

Funding Code "DM"	DCY	- Youth Residential Day Treatment (treatment portion only will be billed)
	DCA	- Adult Residential Day Treatment (treatment portion only will be billed)
	DXT	- Medically Monitored Detoxification Treatment (treatment portion only will be billed)

If the program is JCAHO accredited and Medicaid CERTIFIED for Residential Rehabilitation Youth or enrolled for Medially Monitored Detoxification in a hospital subacute setting, the following procedure codes may be used for billing:

Funding Code "DM"	RHY	- Residential Rehabilitation Youth
	DXD	- Medically Monitored Detoxification

Funding Code "DC"	RHB	- Adult Residential Rehabilitation (Contract funding is billed for the entire treatment episode - treatment and domiciliary.)
	RHY	- Youth Residential Rehabilitation (Contract Funding is billed for the entire treatment episode - treatment and domiciliary.)
	DXD	- Detoxification
	HHD	- Halfway House (Residential Extended Care)
	RHD	- Recovery Home

Psychiatric Evaluation

If the service is for a Psychiatric Evaluation, enter a 'Y.' If not, enter a 'N' in this field. **Entering a 'Y' in this field will link to the established rate for this service, which pays for one event per day regardless of the hours and minutes entered in the time field, and 'PEV' will be automatically displayed in the Procedure Code field.**

Video Counseling

Psychiatric evaluations can be delivered to patients in Level III care via video counseling. Was this psychiatric evaluation delivered via video counseling? Enter 'Y' - Yes or 'N' - No.

Medicaid Spend Down (Due from Patient)

The amount that the patient is responsible for before Medicaid Eligibility can be established. If not applicable, leave this field blank.

Third Party Liability (TPL) Information

If applicable, enter the following fields:

TPL Status - Enter the adjudication status of the amount in question:

01 - TPL adjudicated - total payment shown
02 - TPL adjudicated - patient not covered
03 - TPL adjudicated - services not covered
05 - Patient not covered
06 - Services not covered
07 - Billed insurance/not paid

TPL Payer Amount - Enter the amount of payment received from the third party health resource or the patient.

TPL Paid Date - If the status is **01**, **02**, or **03** - enter the Third Party Adjudication Date. If the STATUS is **05**, **06**, or **07** - enter the service.

NOTE: If the TPL Information is entered on any Service Screen, the admission record for this patient must have completed all TPL demographic information.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted by DASA.
Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted by DASA. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by DASA.

Only for use with funding code "DC." This code voids a record that was submitted **and** accepted by DASA. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made by DASA the void can be made to the record.

Dedicated Funding Category Window (Non-Medicaid)

Dedicated funding is contained in many DASA contracts to ensure that a specific portion of the funding is earned by delivery of services to special populations regardless of whether such funding is contained in a global cost center. Dedicated funding is applicable only to non-Medicaid earnings. Therefore, only services with a funding code of "DC" or "DS" can be tagged as dedicated funding. These specific dedicated funding amounts are contained in contract Exhibit 1 and only those categories, which are funded, will display on the software as follows:

D - DCFS
G - OMT Toxicology
L - Gambling
N - None

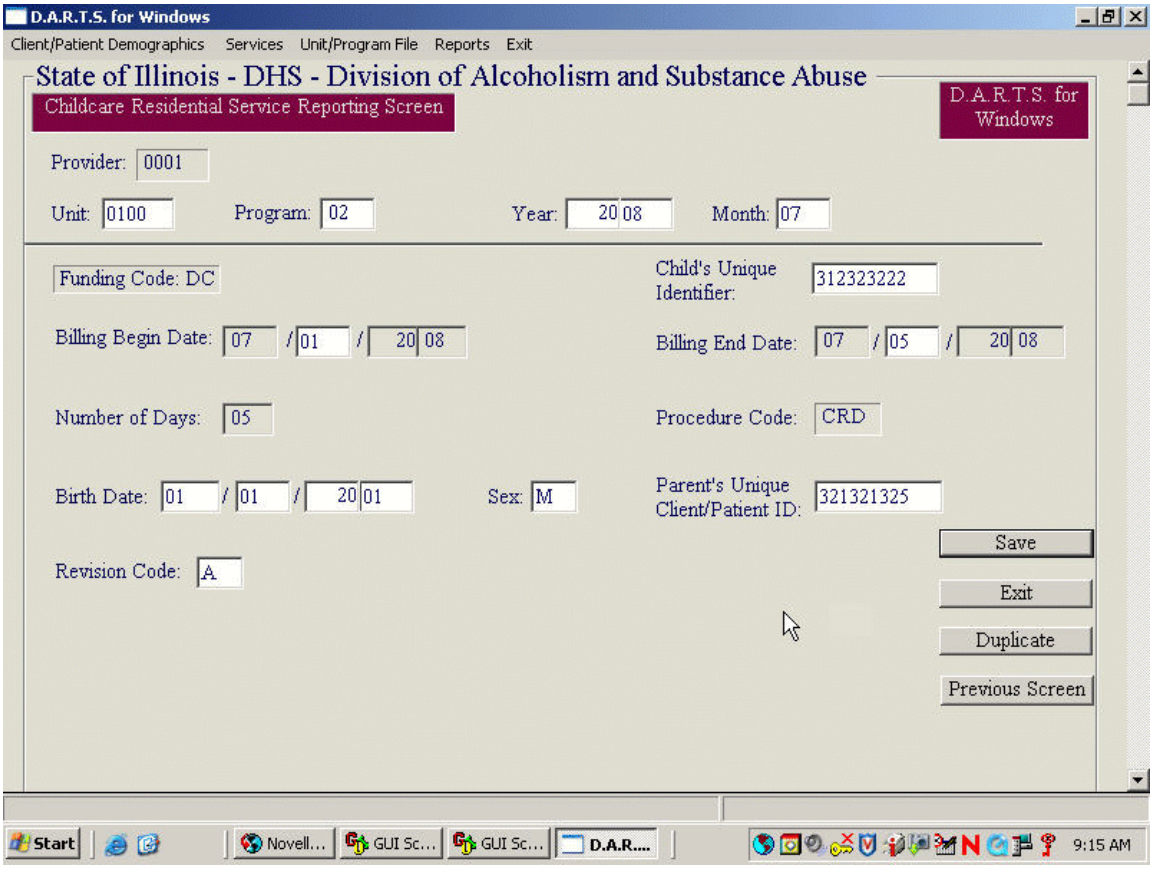
Not all contracts will have dedicated funding obligations. If the contract has no dedicated funding, no window will be displayed. If the contract has dedicated funding but the service being reported does not apply to the patient, select "N" for none. It is very important that dedicated funding is reported correctly. This is how DASA measures compliance with the contract and these amounts are reflected on special dedicated funding reports.

SERVICE REPORTING SCREEN: SPECIALIZED SERVICES

This screen allows for the reporting of toxicology services or services to children in residential care with their parent and is only used by agencies that are specifically funded by DASA to provide these services. The correct report screen will be displayed when the appropriate unit and program number is entered.

SERVICE REPORTING SCREEN: CHILDCARE RESIDENTIAL

When children accompany their parent in residential care and the child occupies a DASA funded bed, the following information is required:



Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year to year. All addresses should match those specified on DASA facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify DASA immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Child's Unique Number

The child's unique 9-digit identifier.

Billing Begin and End Date

The Billing Begin Date through the Billing End Date reports the time period for which the provider is seeking payment. When a Level III service spans two months, enter the service as two separate transactions. Example: There would be two entries for a patient who receives a Level III service from 07/15/2010 through 08/04/2010. The first would be 07/15/2010 - 07/31/2010, and the second would be 08/01/2010 - 08/04/2010.

Number of Days

This number is automatically computed by the dates entered into the Billing Begin and End Date fields.

Birth Date

The child's date of birth.

Sex

The gender of the child. Enter 'M' - Male or 'F' - Female.

Parent's Unique Client/Patient Identifier

The Unique Client/Patient Identifier of the child's parent. The parent must have a demographic record and be receiving services in a residential program.

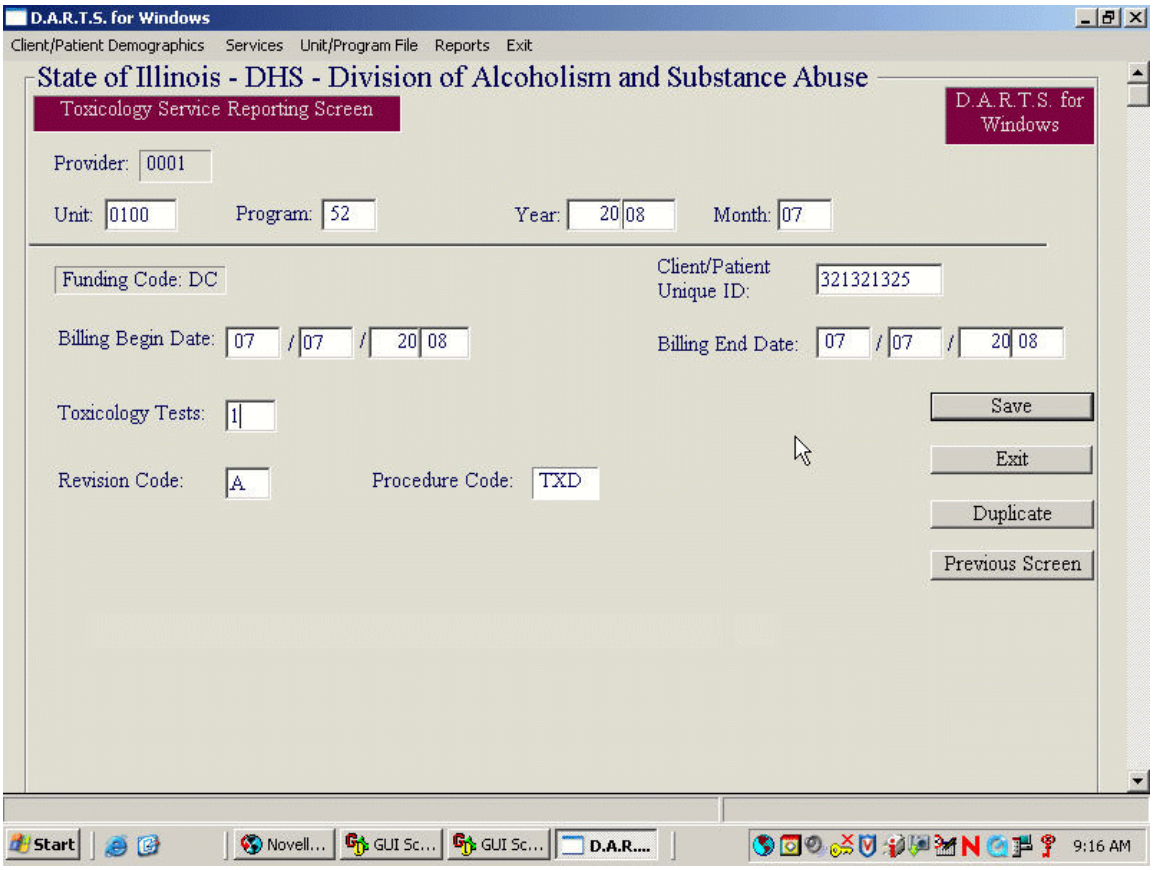
Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted by DASA.
Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted by DASA. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by DASA.
Only for use with funding code "DC." This code voids a record that was submitted **and** accepted by DASA. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made by DASA and the void can be made to the record.

SERVICE REPORTING SCREEN: TOXICOLOGY



Unit/Program

Each service is entered into DARTS using a unit number and program code. **Therefore, before initially entering any data and whenever corrected or updated software is received, all provider unit number and program codes should be verified to reduce the incidence of data rejection.** The Unit and Program number(s) are displayed in the "Provider Unit/Program File." If services are delivered at multiple sites using the same unit number and program code, additional screens will be displayed listing the unique addresses, procedure codes and dedicated funding categories for each individual site. It is especially important to verify **all site numbers** by address for the current fiscal year as these may vary from to year to year. All addresses should match those specified on DASA facility licenses and Medicaid certifications and enrollments. Failure to verify this information or to notify DASA immediately if errors are discovered may result in data errors and possible delays or holds in disbursement or reimbursement for rendered services.

Unique Client/Patient Identifier

The 9-digit Unique Client/Patient Identifier must match a patient with an open demographic record in DARTS, and the service date entered must fall between the admission assessment and closing dates.

Billing Begin and End Date

Record the time period in which the toxicology tests were administered.

Toxicology Tests

The number of toxicology tests on and between the Billing Begin and End Dates.

Revision Code

This field is to add, revise or void a service. The default is 'A' (Add) and is used with all funding codes. The 'R' (Revise) or 'V' (Void) codes are used as follows:

'R' = **REVISE** a record which was previously submitted and accepted by DASA.

Only for use with funding code "DC." This code corrects information on a previously submitted 'DC' claim, which was accepted by DASA. Use of this code will not allow a billing to be changed from one unit/program to a different unit/program or to make any change to the Unique Client Identifier, Staff ID, Service Dates (Beginning or Ending) or Start Time as these fields make a billing unique and allow for matching. The only way to change any of these fields is to send in a 'V' (Void) claim for the original billing, and then an 'A' (Add) claim for the corrected billing.

'V' = **VOID** a record which was previously submitted and accepted by DASA.

Only for use with funding code "DC." This code voids a record that was submitted **and** accepted by DASA. The 'V' record needs to be entered exactly as it was in the original submission, so that a match can be made by DASA and the void can be made to the record.

SECTION VI

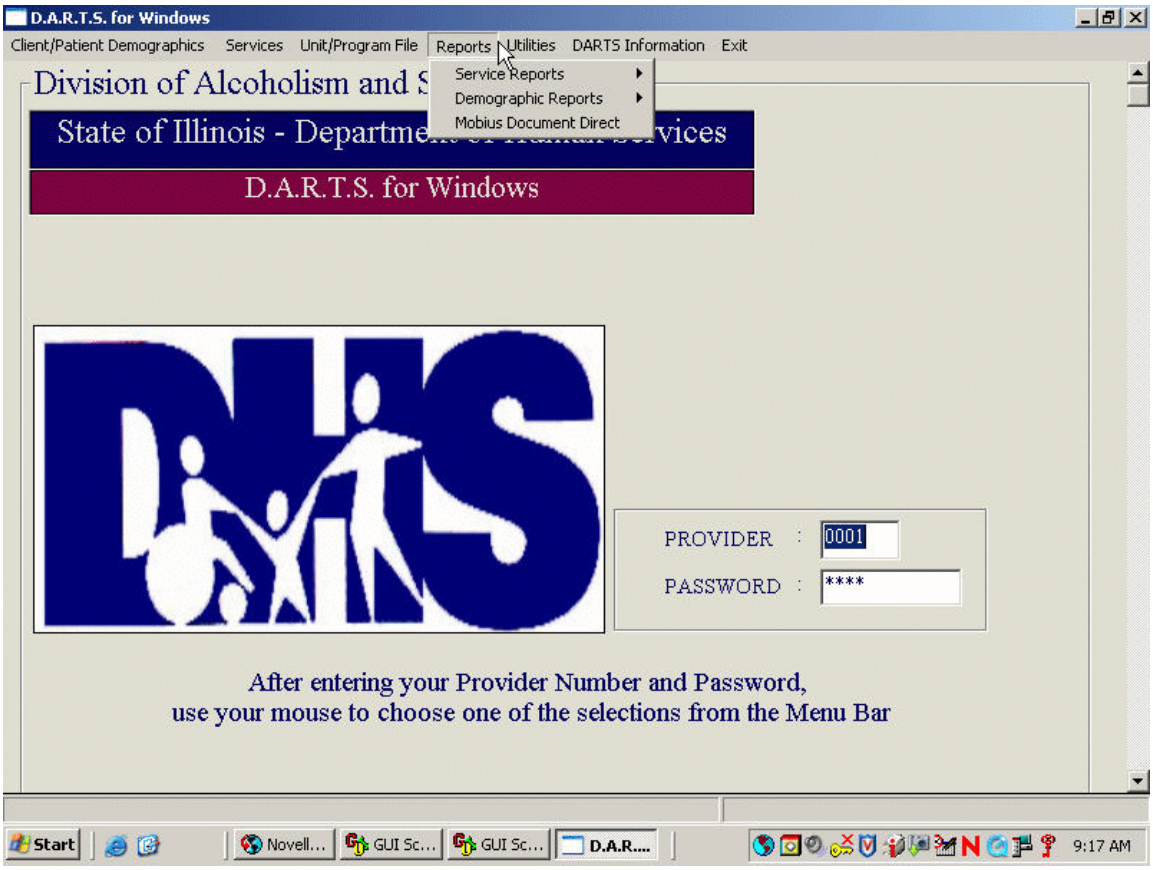
PC Reports - Main Menu

What are PC Reports and How Do I Use Them?

PC reports are produced from your computer and are very important for reconciling and verifying data that is sent to DASA against DARTS Mainframe Reports and Medicaid billings. All PC reports should be printed and reviewed prior to data submissions to ensure that accurate data is submitted.

These reports are simple to use and may either be printed or displayed on the screen. As many types of reports as needed may be viewed or printed.

To access the PC Report section, choose the Reports option from the Menu Bar. No data will be damaged or destroyed when utilizing these reports.



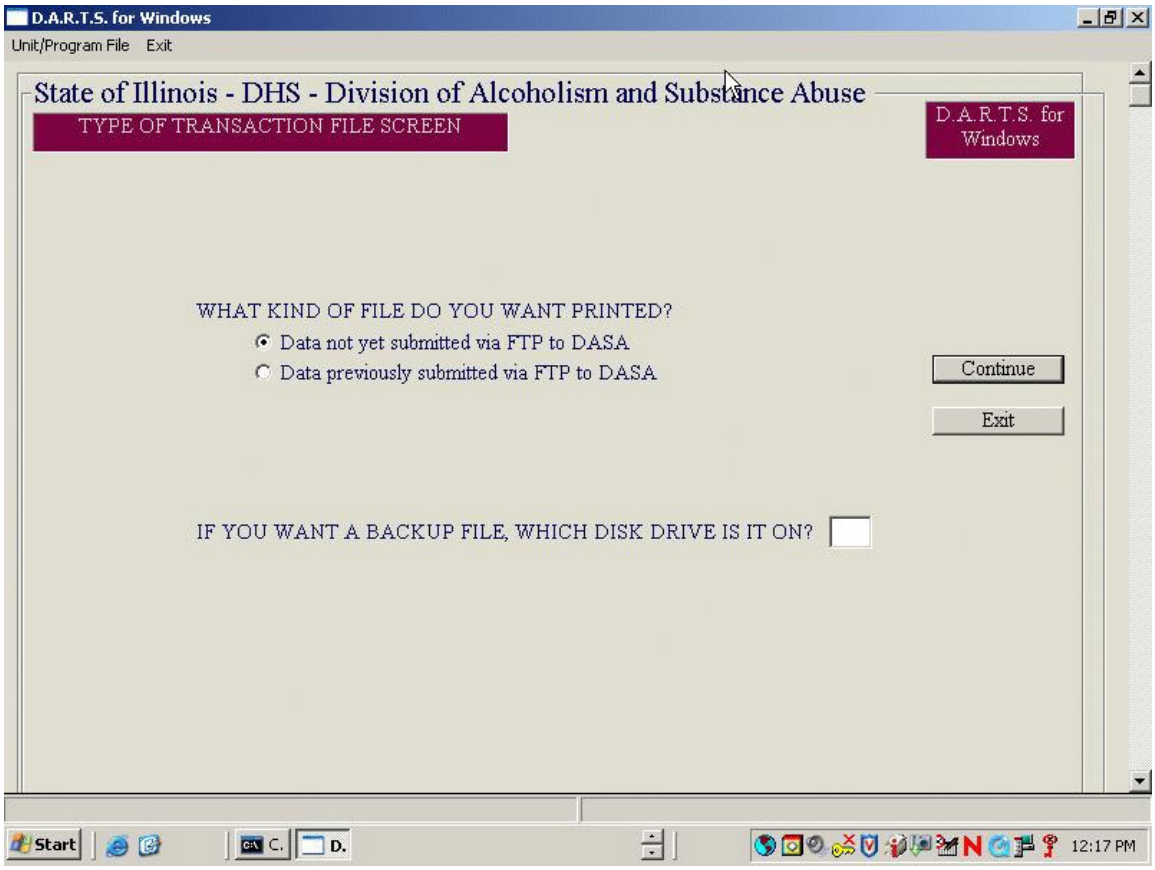
Reports can be printed from data contained in the following two file types:

1) Services: includes service data entered into DARTS, which will be submitted, via FTP.
2) Demographics: this includes reports generated from the client/patient master file and transaction files, which are sent via File Transfer Protocol (FTP).

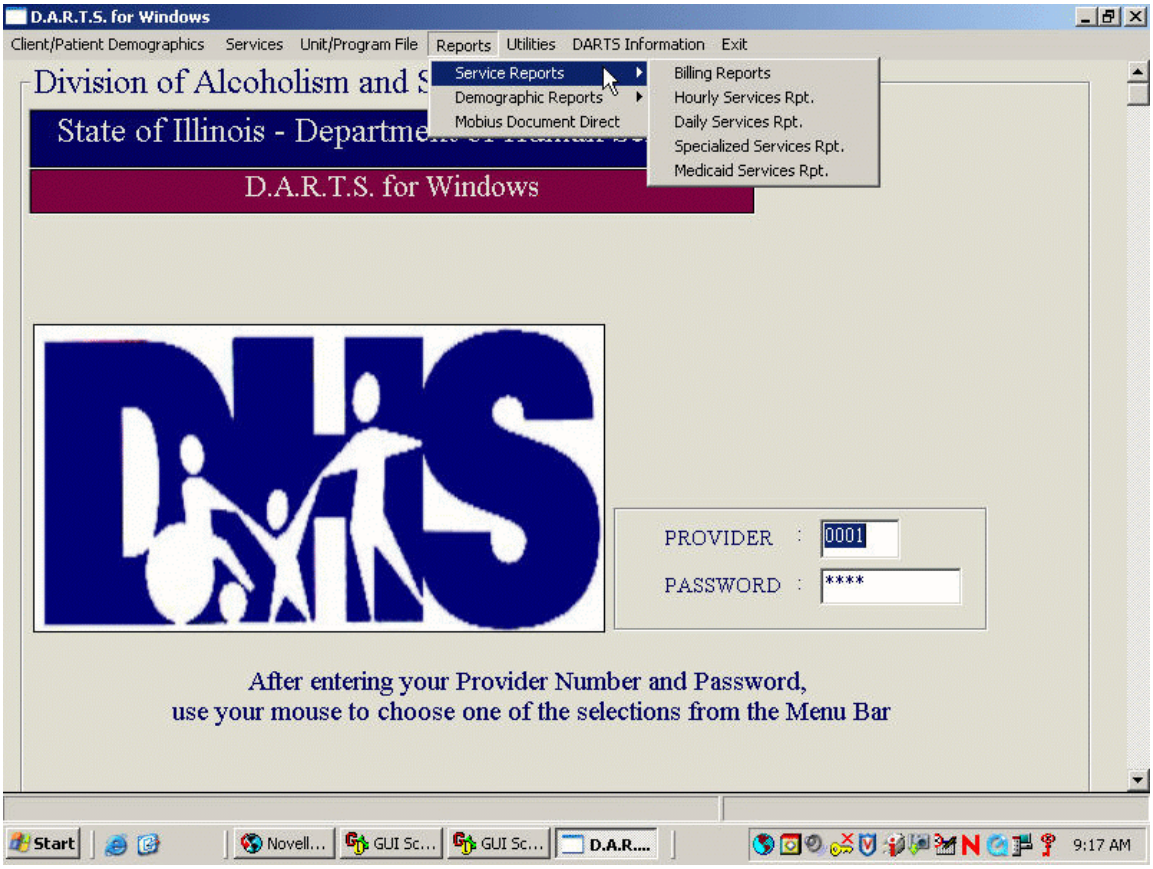
The first screen displayed provides a choice for the type of transaction file that will be printed:

- data not yet submitted via FTP to DASA, OR

- a back-up file that contains data previously submitted via FTP to DASA. When choosing a back-up file, the resident drive must be entered. The resident drive is usually hard drive C or the network drive.



SERVICE REPORTS: What are the Types of Service Reports that Can Be Printed?

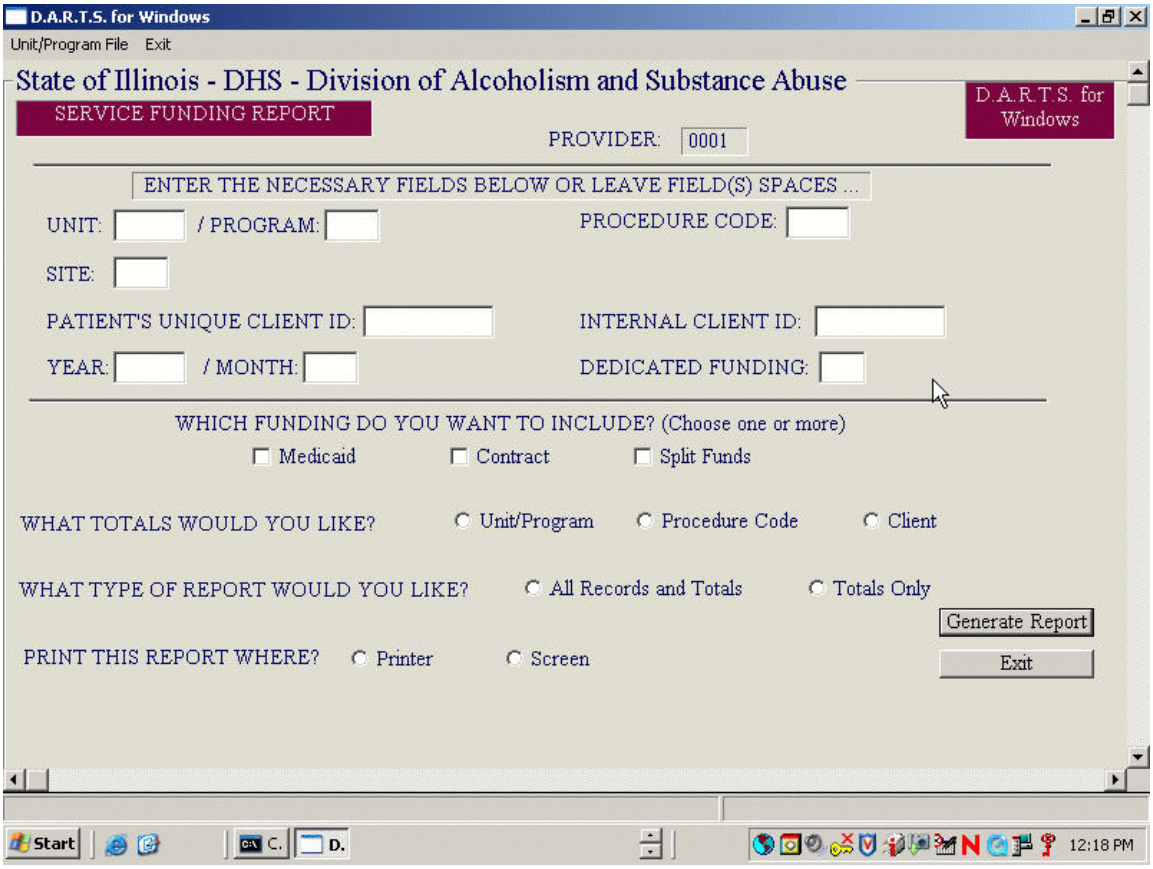


There are five choices for service reports as follows:

Billing Report: This report should be printed prior to the submission of any services to DASA to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports received from DASA. When printing this report, the following choices are available:

- Field Specific Information: Unit/Program, Procedure Code, Unique Client/Patient Identifier, etc.
  By entering data into one or more of these fields, only the records, which match the criteria entered, will be printed. (i.e., entering "**RHY**" in procedure code will print only patients billed to Level III Youth; entering the patient's Unique Client/Patient Identifier will print only that client/patient's billings.) Any or all of the above fields can be left blank.
- Funding Codes: DM, DC or DS
  Enter an 'X' next to each of the funding codes to be included in the report. One or more funding codes may be chosen.
- Clients/Patients to be included:
  This allows for tracking of all clients/patients or only DCFS clients/patients.
- Unit/Program, Procedure Code, or Unique Client/Patient Identifier Order:
  This option will allow sorting of the report in one of three different ways: 1) in order of Unit/Program, 2) in order of Procedure Code, or 3) in the order of Unique Client/Patient Identifier.

- Type of Report:
  This option allows printing of: 1) Both Records and Totals, OR 2) Totals Only. The first report (Records and Totals) is useful to verify that a client/patient has billings for the correct number of hours, etc. This type of report will also list the date of service and procedure code, which is useful when verifying monthly totals. Unit/Program Totals are also printed. The second report (Totals Only) provides one page totals for every unit/program entered.



Hourly Services Report: This report should be printed prior to the submission of any services to DASA to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports received from DASA. When printing this report, the following choices are available:

- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.

  Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient's records, or data for a particular service month, enter the desired combination.

- Type of Report:

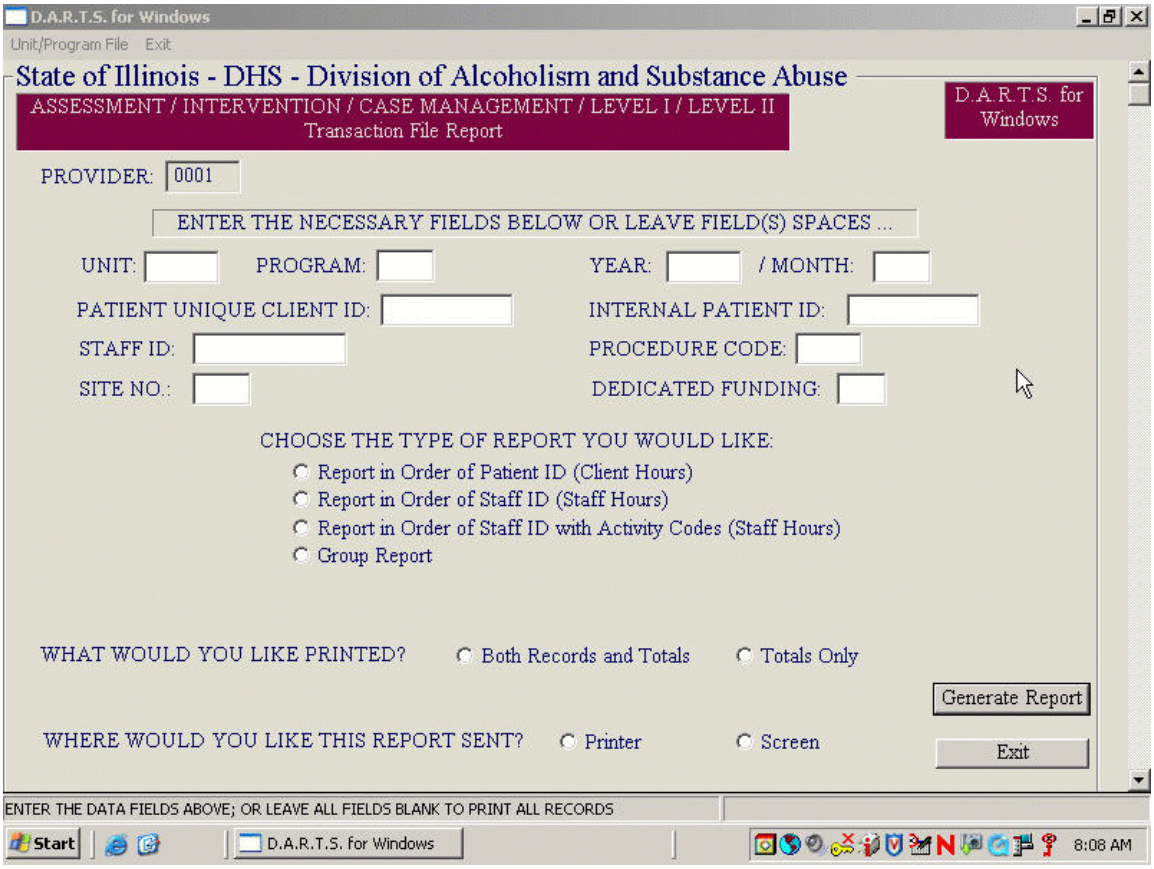
  1) Report in Order of Client/Patient ID (client/patient hours) - This will print a service report in order of client/patient ID's, and will total the hours entered for every client/patient. Hours accumulated are referred to as "Client/Patient Hours."

  2) Report in Order of Staff ID (staff hours) - This will print the report that may monitor the activity of each staff. Totals of hours and events will also be printed for each staff member. Hours accumulated are referred to as "Staff Hours."

3) Report in Order of Staff ID with Activity Codes (staff hours) - This report will print in an order that allows monitoring of the hours of each staff, while also totaling hours for each of the activity codes entered for that staff member. This is especially useful when using the activity code field for monitoring special services. Hours accumulated are referred to as "Staff Hours."

4) Group Report - This report will print all of the clients/patients in each group and will print in the order of Group ID.

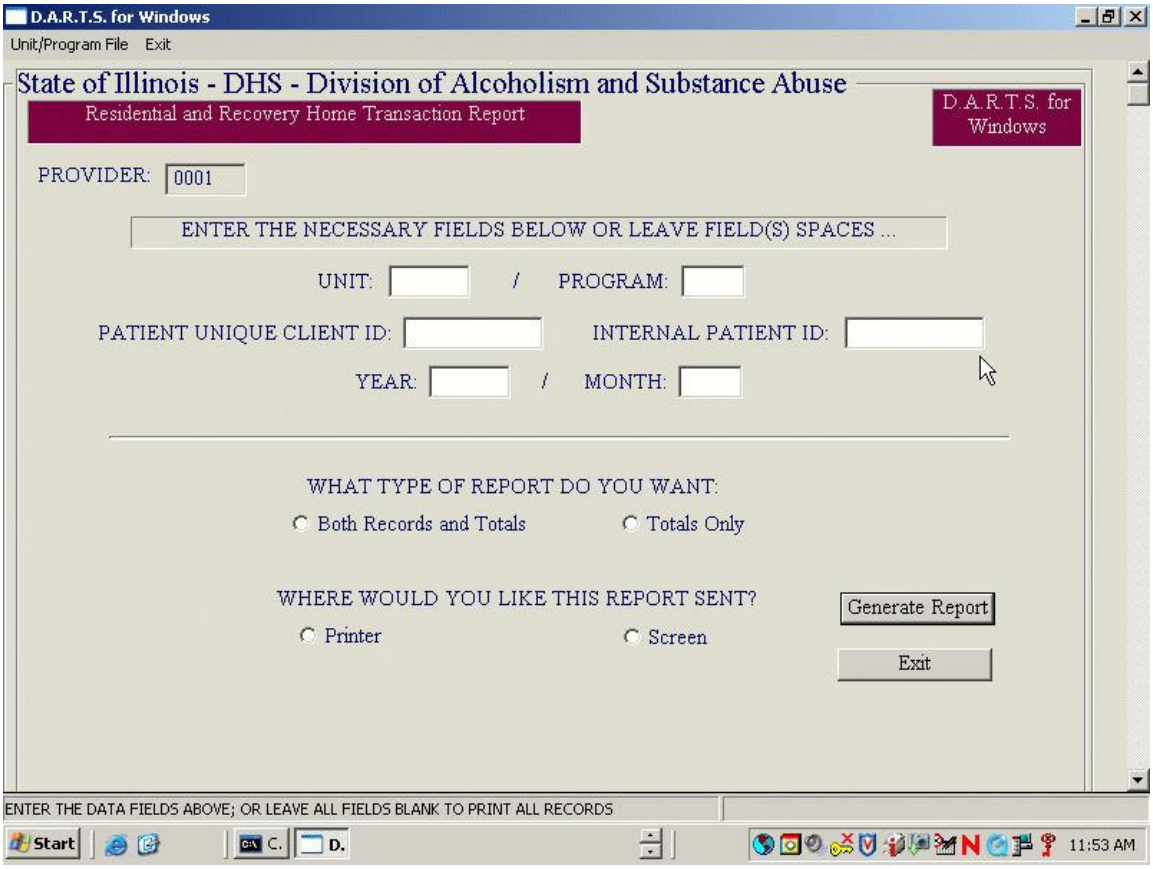
- Clients/Patients to be Included
  This allows for tracking of all clients/patients or only DCFS clients/patients.
- Records to be Printed
  Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).



Daily Services Report: This report should be printed prior to the submission of any services to DASA to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports received from DASA. When printing this report, the following choices are available:

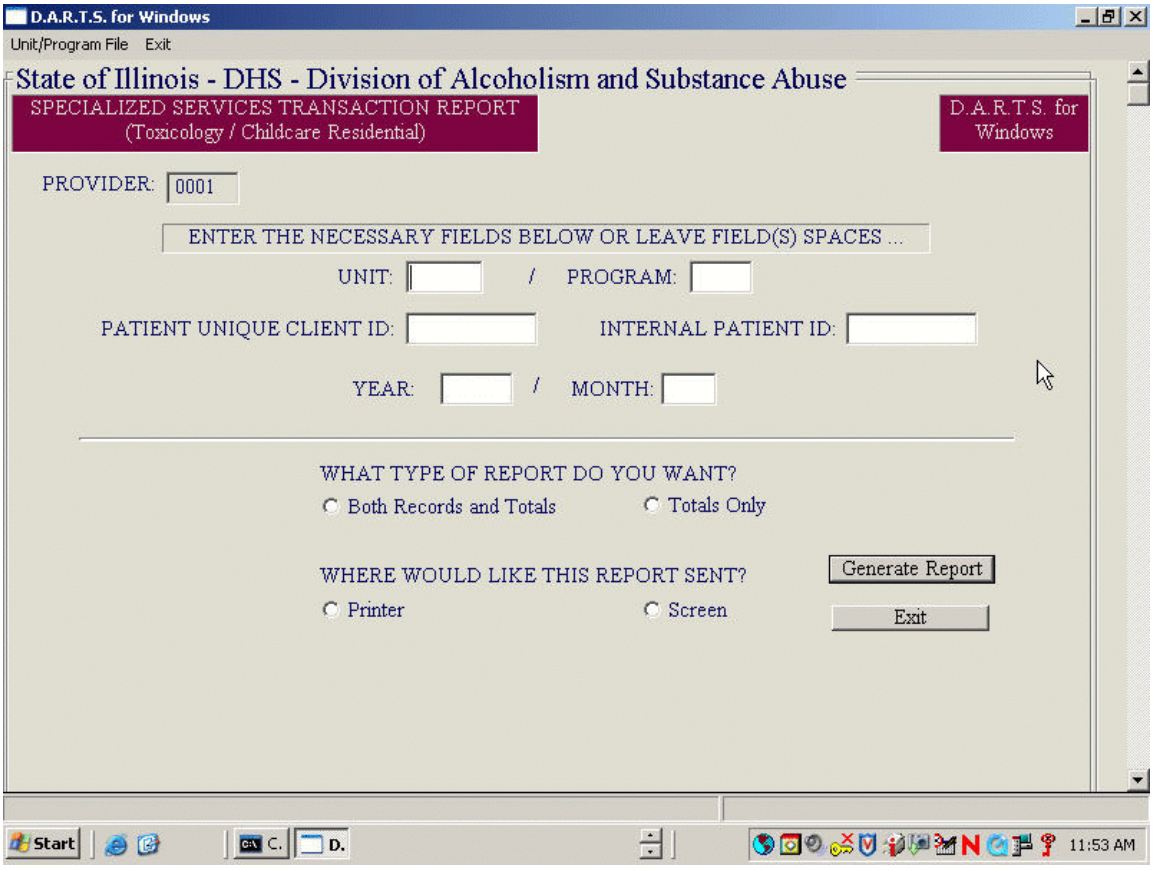
- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.
  Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient's records, or data for a particular service month, enter the desired combination.

- Clients/Patients to be Included
  This allows for tracking of all clients/patients or only DCFS clients/patients.
- Records to be Printed
  Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).



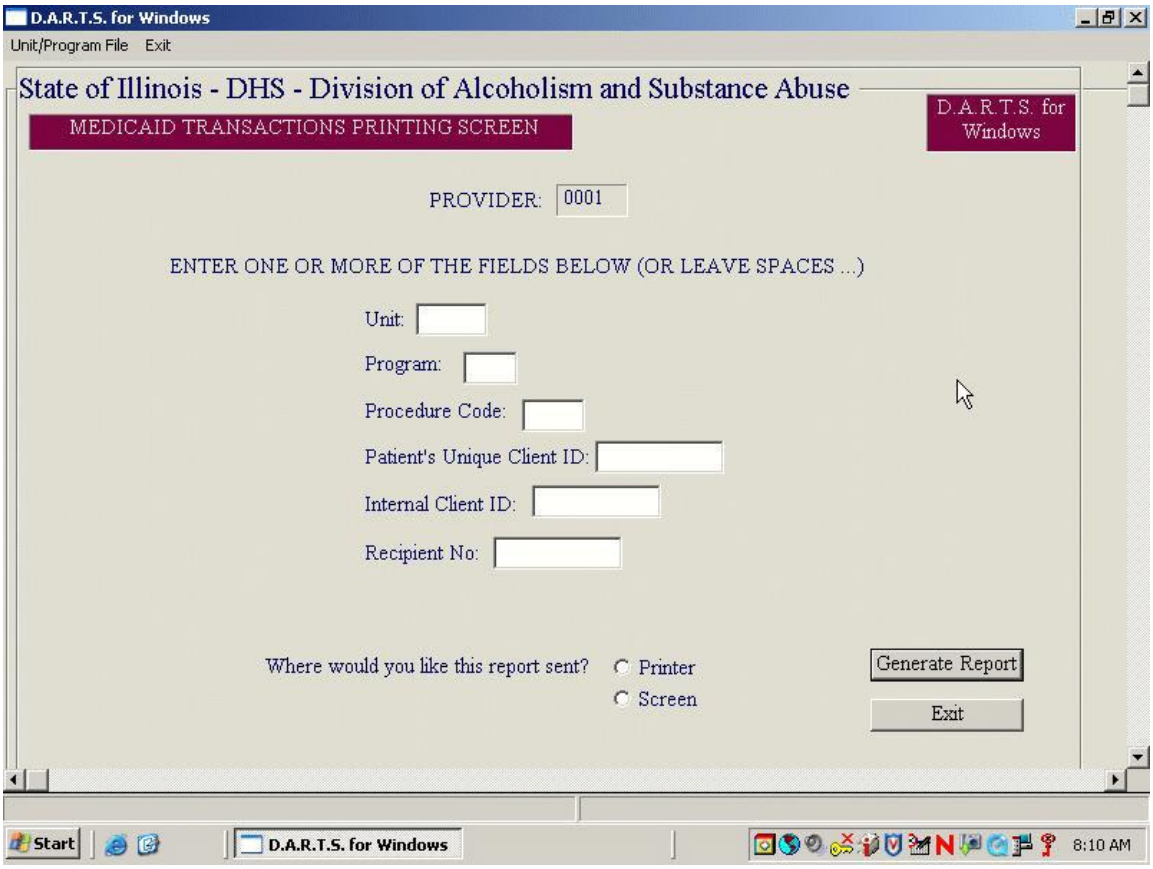
Specialized Services Report: This report should be printed prior to the submission of any services to DASA to ensure accuracy. The printed report can also be used to compare service totals on DARTS Mainframe Reports received from DASA. When printing this report, the following choices are available:

- Unit/Program, Unique Client/Patient Identifier, Internal ID, Service Year/Month, etc.
  Leave these fields blank to print all services. However, to print only a specific unit and program, a particular client/patient's records, or data for a particular service month, enter the desired combination.
- Client/Patients to be Included
  This allows for tracking of all clients/patients or only DCFS clients/patients.
- Records to be Printed
  Choose to print 1) Both Records and Totals, OR 2) Totals only. The first report (Records and Totals) can be very useful to verify that a client/patient has been entered into DARTS for the correct number of hours, etc. This type of report will also list the date of service, which is useful when verifying monthly totals. Unit/program totals are also printed. The second report (Totals Only) gives one page totals for every unit/program entered. When printing the Totals Only Report, the numbers may reflect service hours for multiple months (in case more than one month of data was entered since the last submission).

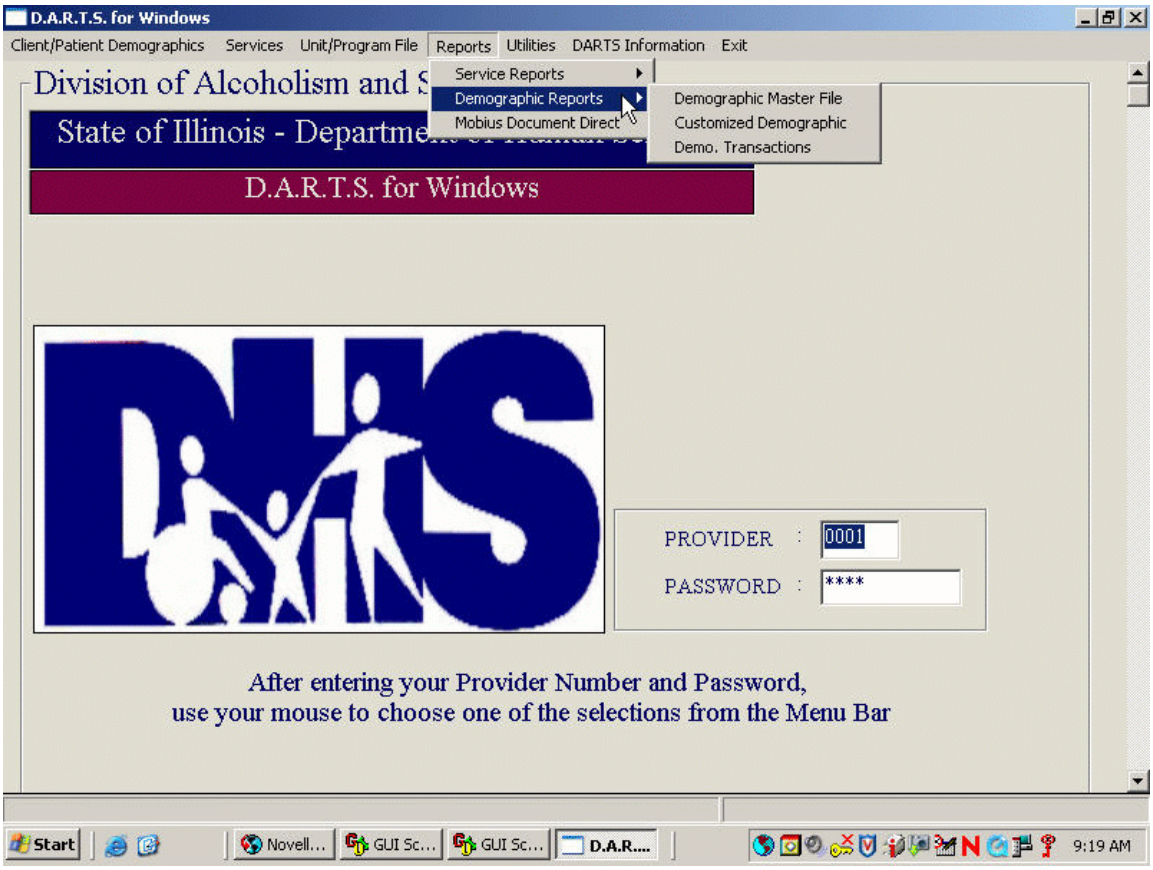


Medicaid Transaction Report: This report lists all of the information about each Medicaid billable service. Each billing will print one full page and it is strongly recommended that this report be used to reconcile Medicaid billings. The following fields are referenced on this screen:

- Unit/Program, Procedure Code, Client/Patient Unique Identifier, Internal Client/Patient ID and Recipient Identification Number.

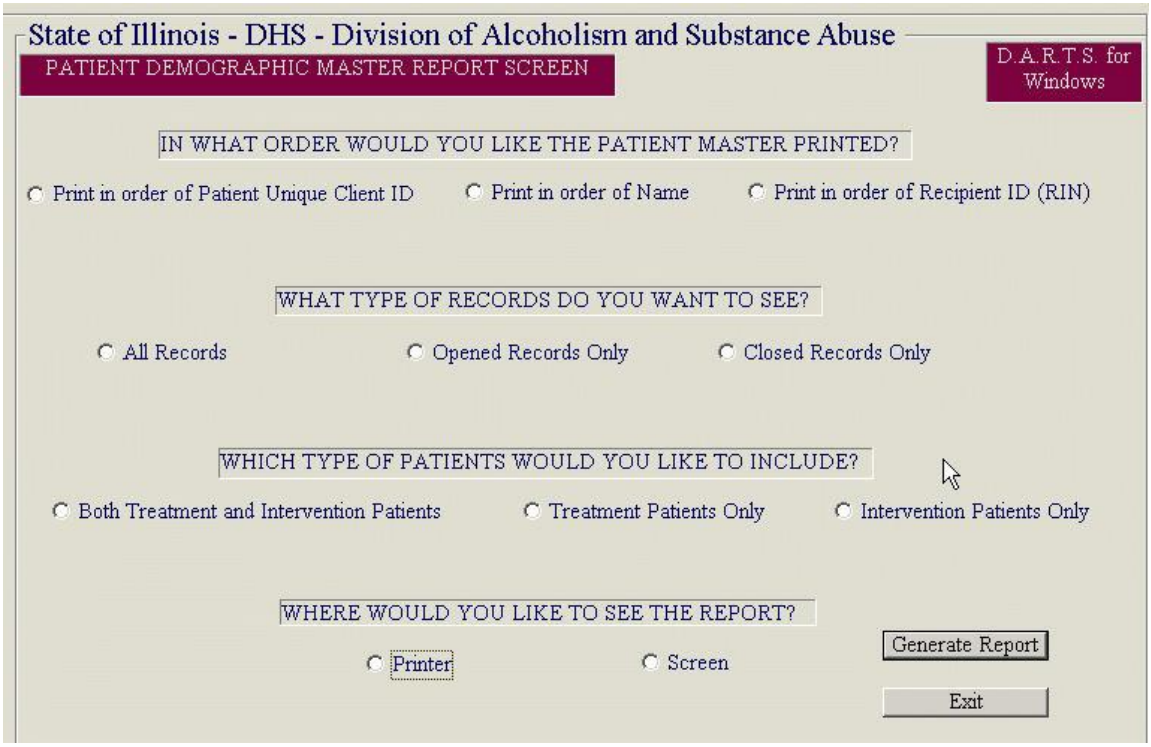


DEMOGRAPHIC REPORTS: What are the Types of Demographic Reports that Can Be Printed?

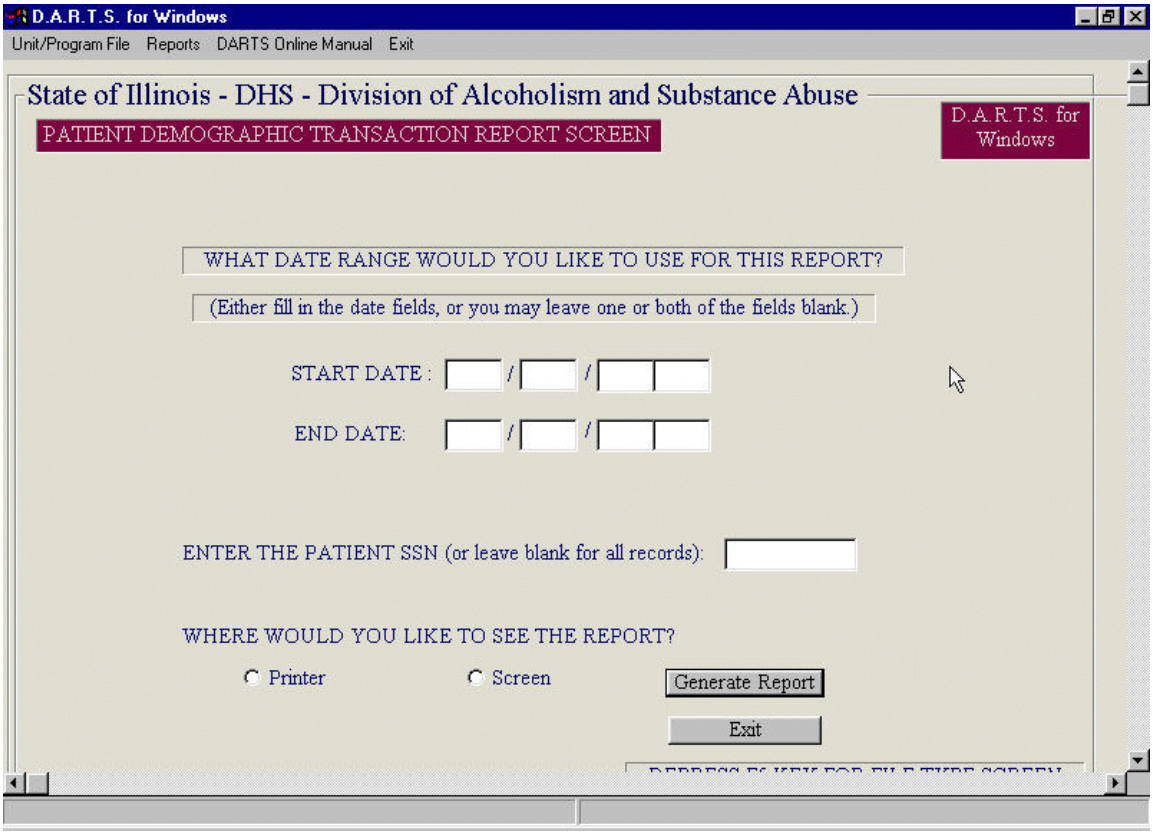


There are three choices for demographic reports as follows:

Demographic Master File Report: This report lists all clients/patients who have an admission record in DARTS. Since there may be thousands of patients who have been entered, view the report on the screen before printing. Choices are given to customize the report. These choices include 1) printing in order of the Unique Client/Patient Identifier or Name, AND 2) printing all records, only admission records, or only discharge records.



Client/Patient Demographic Transaction Report: Choosing this option will print all one or all client/patient demographic records that have been submitted to DASA. Every time a client/patient's record is added to, changed or deleted, that data is written onto the hard drive. This report will show these changes and print demographic, problem area, and discharge information. This date reflects information entered on this date—not admitted on this date. (i.e., a review of all admission records entered into the PC today.) In most cases, it is not necessary to print or view this report every month. Each client/patient record takes up one printed page, therefore, only refer to the report when necessary for error reconciliation. The date range feature allows the date range to be chosen so that only demographic records added or changed within that data range are printed.



Mobius Document Direct: Choosing this option will allow providers to view DARTS mainframe reports online. (See Mobius User Manual Addendum I for more detailed information.)

The following DARTS Mainframe Reports are available on Mobius:

WEEKLY DARTS REPORTS (ran every Monday after 5:00 p.m.)
PASDMWR1 - Client Update Report (Accepted/Rejected Client Demographic Records)
PASDMWR2 - Service Accepted/Rejected Update Report
PASDMWR3 - Service Accepted/Rejected Summary Report

MONTHLY DARTS REPORTS (ran every second Monday after 5:00 p.m.)
PASDMRR1 - YTD Site Report by Month
PASDMRR2 - Service Report Code Counter by Month
PASDMRR3 - YTD Activity Report
PASDMRR5 - Active Client Listing
PASDMRR6 - All Client Listing
PASDMCR7 - All Service Setting Codes
PASDMCR8 - Services and the Opening Dates They are Tied to
PASDMXR1 - Warning Report of Openings with No Service Activity Within the Last Three Months

PASDMXR2 - Openings with No Service Activity Within the Last Four Months that have been Administratively Closed

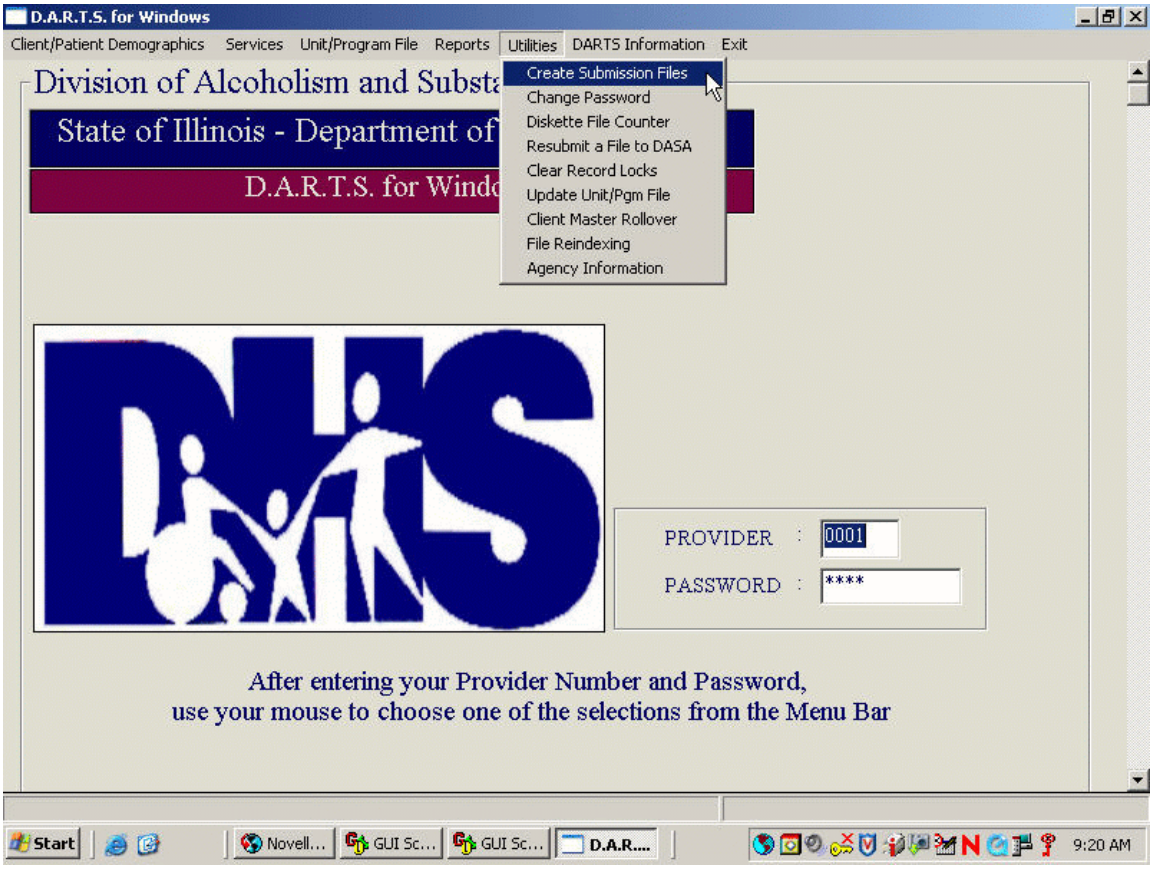
QUARTERLY DARTS REPORTS (ran after the completion of each quarter within a fiscal year)
These reports will begin with letters “PASDMQ”.

Pharmacy/OMT reports begin with the letters “PASPH”.

Utility Functions - Main Menu

What are Utility Functions?

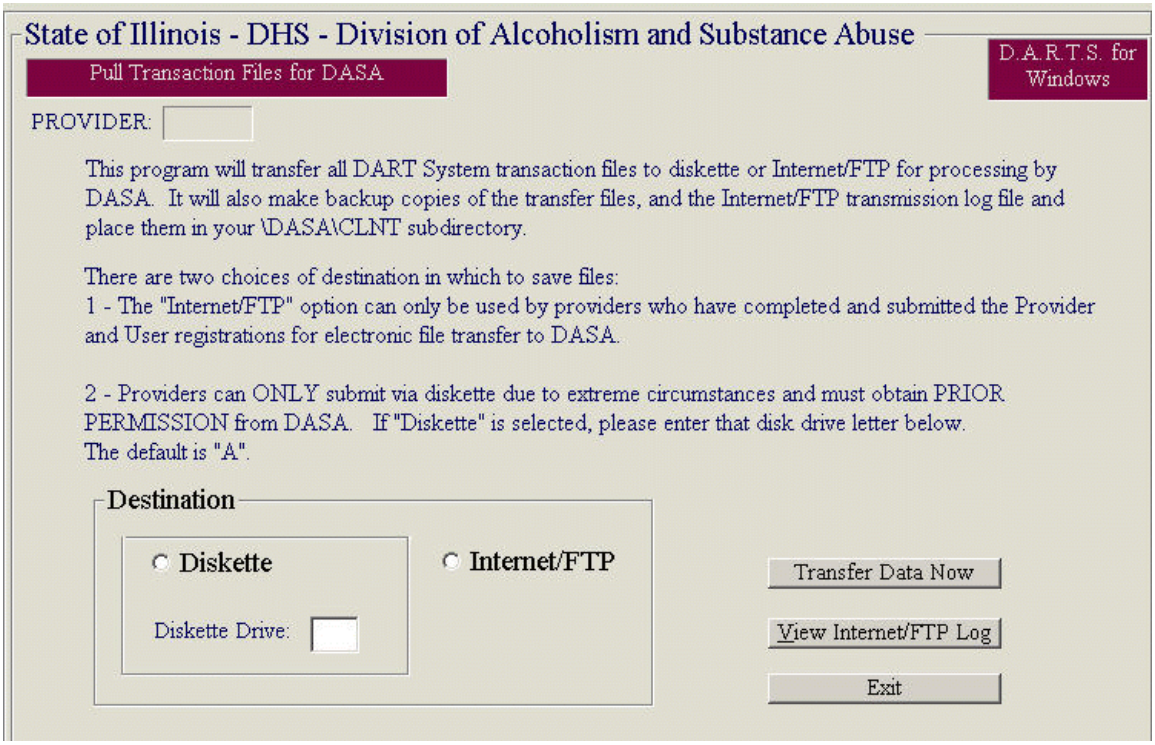
Utility functions are used to submit service data to DASA, change passwords, and load software updates and remove out of date discharge records from the client/patient admission master file.



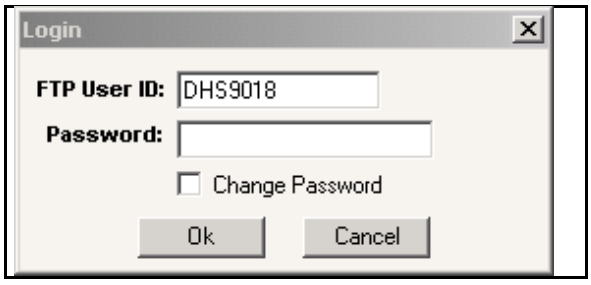
The following information will be helpful in using utility functions:

Create Submission Files: This option extracts service data entered into DARTS. File Transfer Protocol (FTP) is the required method of submission. However, this section contains information on FTP and diskette submission in the event that diskette submission is necessary.

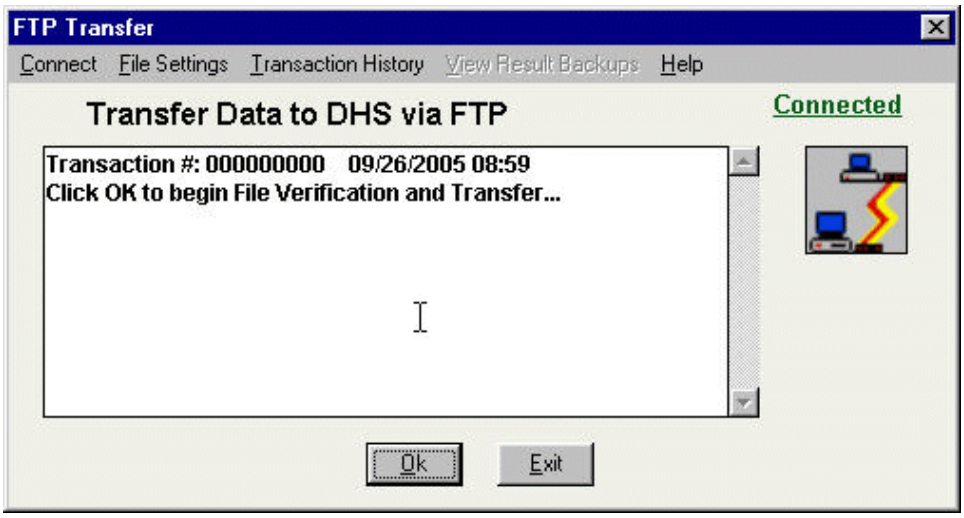
FTP Submission: Once the organization has successfully registered with DHS, files may be transmitted via FTP. If a fire wall is utilized, then port 2021 must be open for connectivity. A connection to the Internet is required. Before the first FTP submission, click on "Agency Information" from the DARTS Menu Bar. This screen allows the setup of your FTP Provider ID and e-mail addresses. Information on this screen needs to be entered only one time.



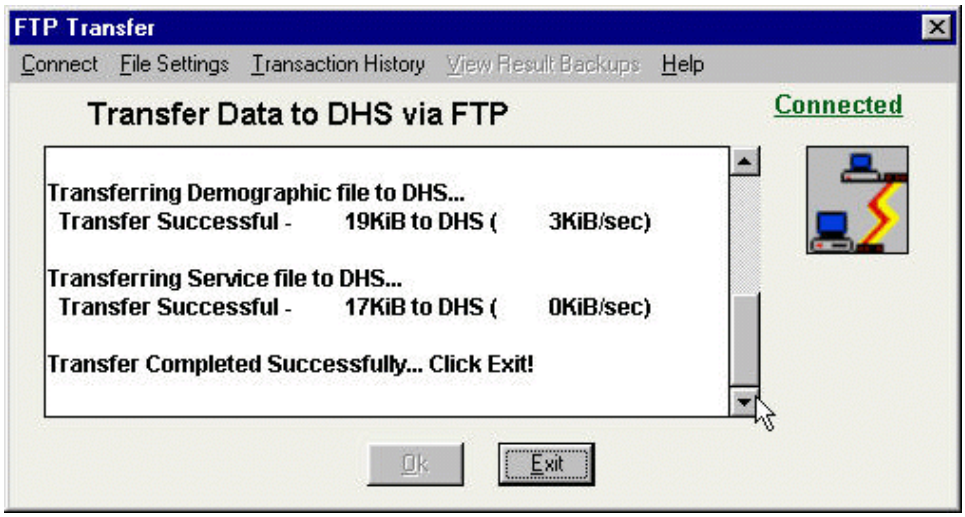
To submit your DARTS data to DHS, select ***Create Submission File*** from the ***Utilities*** drop down menu. Click **Transfer File Now** to continue or **Exit** to abort the transfer. Next, the Login window will be displayed. Enter your **FTP User ID** and **Password** then click **Ok** to continue. If an error box is displayed, check that the FTP User ID and Password are correct. **Note**: The first time you log into the system, enter your FTP User ID as the password and then you will be prompted to change your password. The password is case sensitive and must be changed every 30 days.



The above screen appears after successfully connecting to the FTP server. (If your password needs to be reset due to inactivity or other problems, contact the Customer Solution Center - IT Support for DHS at 1-800-366-8768. Press '2' and then '11' to be connected with a representative.)



Click **Ok** on the screen below to begin the transfer to DHS. The FTP Transfer dialog box will display information about the transfer process. To verify a successful transfer, scroll to the bottom of the dialog box to view the transfer results.



Diskette Submission: Providers can ONLY submit data via diskettes due to extreme circumstances and must obtain prior permission from DASA. If a diskette is mailed, place the diskette in a mailer and mail it to the following address:

Illinois Department of Human Services/DASA
Harris Building, Harris II
100 South Grand Avenue East, Second Floor
Springfield, Illinois 62762

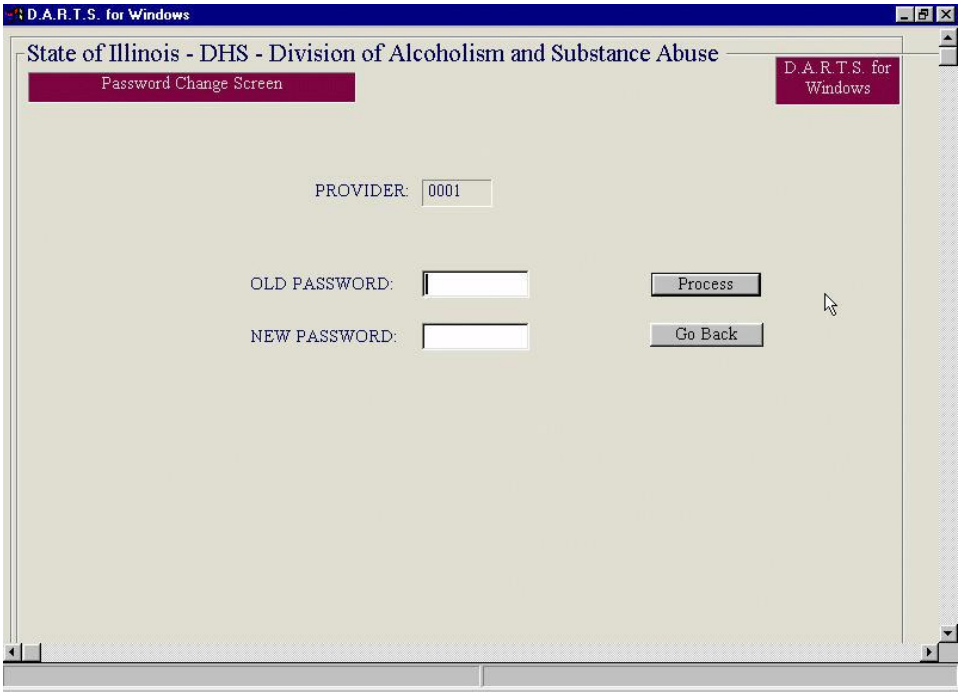
When data is successfully transmitted to DHS, a back-up copy of those files on the diskette is automatically copied into the DASA\CLNT subdirectory. These files are named in the following format:

D1080707.FCT

In the above example, the name of the file is comprised of three parts:

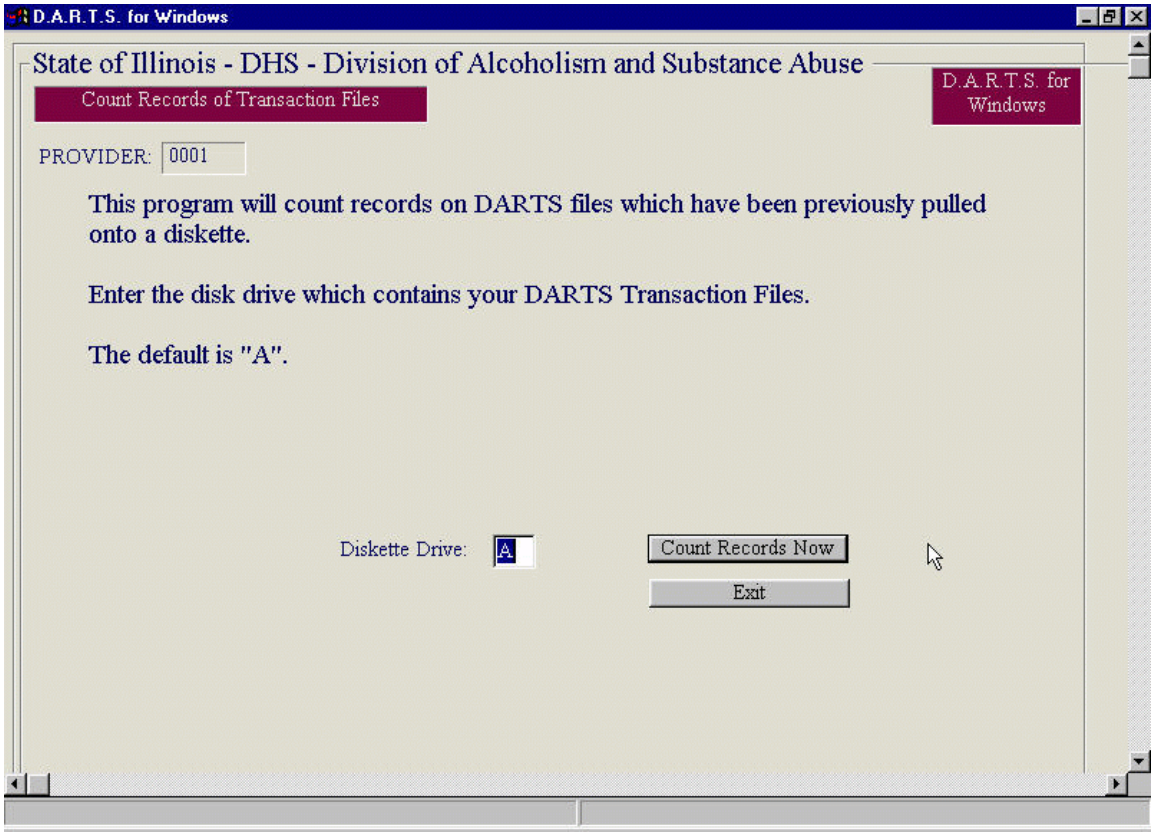
1) D1 represents the number of diskettes used to complete the extract process. If it took two diskettes to extract, there would be one file named D1080707 and another named D2080707.
2) The second component of this name is 080707. This is the extract date (year/month/day). In this example, the extract was done July 7, 2008.
3) The last part of this name is the extension, or the part that follows the period. In this case, the file represents the FCT file, which is the patient admission file.

Change DARTS Password: A password is required on the DARTS Main Menu for entry into the system. The default password is DARTS; however, a new password can be entered into DARTS. From the Menu Bar, click on "Utilities," then "Change Password." Enter both the old password and new password and click on "Process" or press enter.

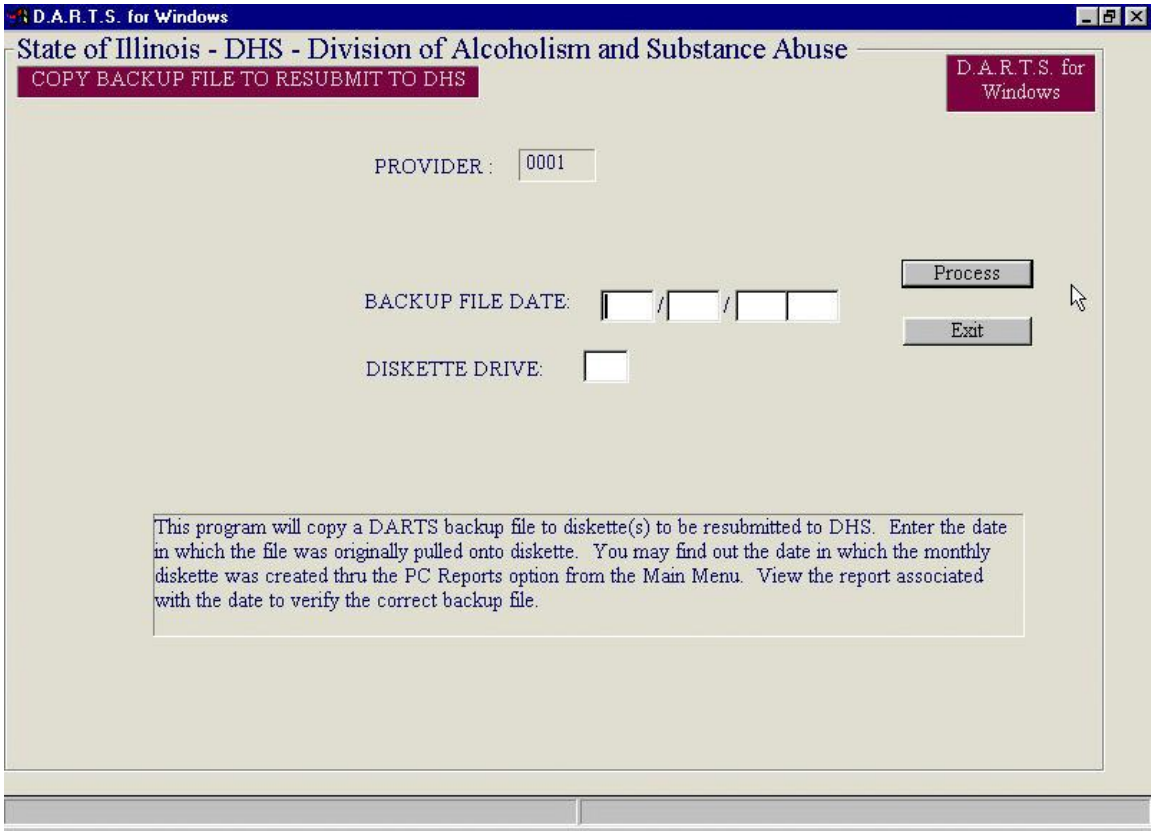


Diskette File Counter: This utility function will count records in DARTS, which have been previously submitted to DASA.

- From the Menu Bar, click on "Utilities," then "Diskette File Counter"
- Insert the diskette containing the records to be recounted
- Identify the drive, which contains the diskette
- The screen will display the file name and the number of records contained on each of the files on the diskette



Resubmit a File to DASA: This program will copy a DARTS back-up file to diskette(s) to be resubmitted to DHS. Enter the date in which the file was originally downloaded. The date in which the file(s) were downloaded can be found through the PC Reports Option from the Main Menu. View the report associated with that date to verify the correct back-up file.

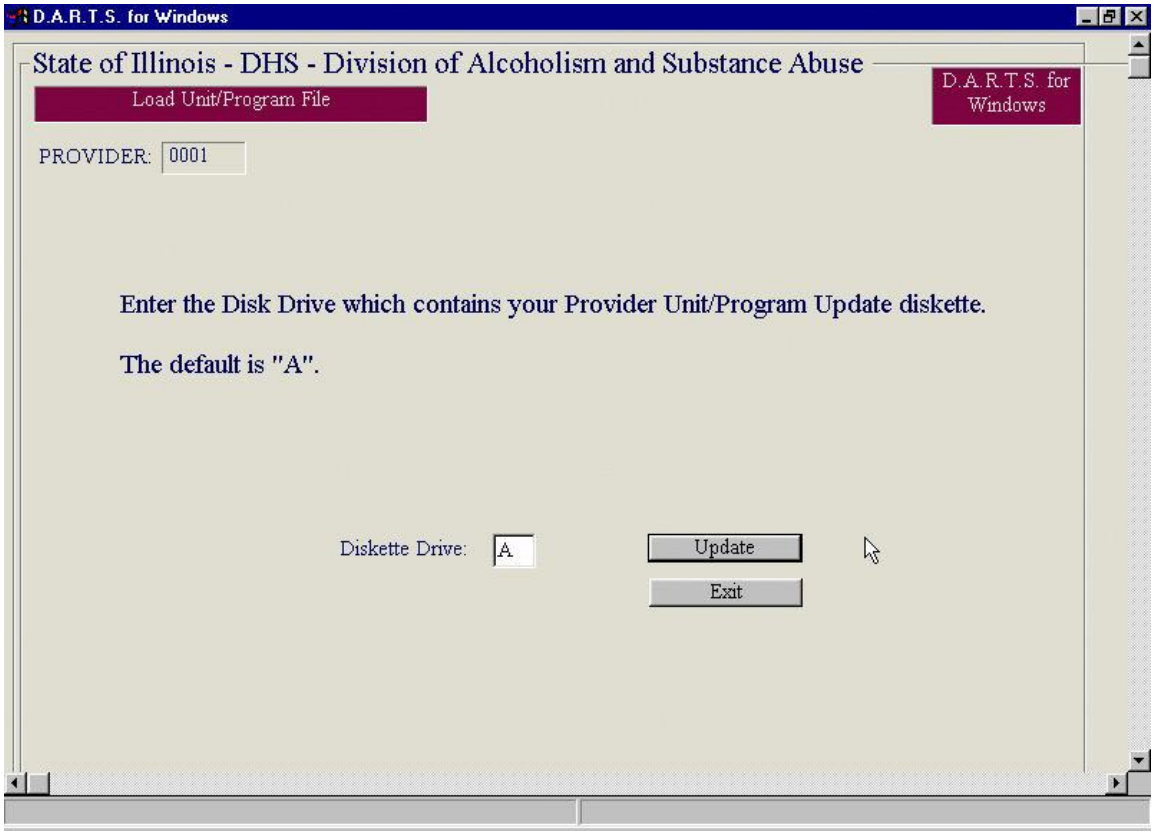


Clear Record Locks: Since DARTS provides for use on local area network (LAN) systems, record locking is provided. In the event a record cannot be accessed and the message "Record is locked by LAN" is displayed, this option can be used to clear all record locks.

Update Unit/Program File: Periodically, files are e-mailed from DASA, which will update the unit/program file. The provider unit/program file contains all of the valid unit/program combinations. Updates of this file are sent at the beginning of every fiscal year, as well as throughout the year if there are any additions or changes. After receiving a file, please update the provider unit/program file in a prompt manner! Check the provider unit/program file by choosing "Unit/Program File" from the Menu Bar.

To update the Unit/Program File, copy the unit/program attachment file directly to your \dasa\fdb folder OR copy the e-mailed file to a diskette and update using the following steps:

- From the Menu Bar, click on "Utilities," then "Update Unit/Program File"
- Load the update diskette
- Identify the drive, which contains this update diskette
- After successfully updating, the screen will display a successful message



Client/Patient Master Rollover: This option allows for removal of out-of-date discharged records from the Client/Patient Admission Master file. Each year as more and more clients/patients are admitted, the Admission Master file may become quite large and can slow down the system or fill up the hard drive. It may become necessary and/or desirable to "clean off" some of these old records. First view or print the Client/Patient Admission Master file report from the PC to see what the client/patient database looks like.

When removing a large number of discharged clients/patients, the rollover procedure is ideal. Two dates are entered during this process. First, the current date, and second, the date for deletion of discharged clients/patients. (i.e., if 07/01/06 is selected as the date to use to delete records, only discharged records, which were opened before 07/01/06, will be deleted.) The system will not allow a date to be selected within the fiscal year.

SECTION VIII

Backing Up DARTS Files!

Computers have hard disk crashes or users can delete files by accident. Backing up the system is a quick and painless experience, and COULD SAVE DAYS OR WEEKS OF WORK!

Computers come equipped with several different options for back-up. Depending on the type of computer, the command on how to back up computer data files varies.

The Client/Patient Admission Master File (DASA\CLNT\CLNTMAST.FIL) is located on the hard drive or network drive and contains all of the information about admissions and discharges. If the computer crashes, there are only two ways to reinstall all admissions and discharges: 1) restore the data from the most current back-up OR 2) re-enter all admission/discharge records. If there is no back-up, all records must be re-entered.

Decide on the best way to back up files but it is suggested this process occur at least weekly. This will not only prevent loss of DARTS data, but also Word Processing files, Spreadsheet data, etc. All data files for DASA are resident in the DASA\CLNT subdirectory on the computer.

SECTION IX

Help Desk Guidelines

The DASA Help Desk can be reached through e-mail at DHS.DASAHELP@ILLINOIS.GOV or through fax at 217-558-4656. All questions to the Help Desk should specify the problem and include examples, if appropriate. Be sure to include the Provider name and four digit Provider number and the name, number and e-mail address of the contact person so the Help Desk staff can respond. Most Help Desk requests are answered by DASA staff within three working days. However, questions that must be referred to other DHS offices may take longer. For questions regarding DASA reports on Mobius, please specify the name of the report.

It is very important to be familiar with the drive in which DARTS resides. Most systems use the C drive to keep DARTS, but others may use D:, E:, etc. For LAN users, it is important to know what "Login ID" was used when the problem occurred. Different login ID's are given different rights on LAN systems, and this could be the basis of the problem. When a problem occurs entering data into DARTS, write down the *COMPLETE* error message, which is displayed, on the bottom of the screen. Without this information, staff cannot assist with correcting the problem. Depress the "Print Scan or Print Screen" key while both the message and data in error are still displayed on the screen and this will print a copy of what the screen looked like when the error was encountered. If the error message concerns a particular field (i.e., Living Arrangement, Annual Income, Recipient Identification Number, etc.), please refer to that field in this manual to check for the definition and valid field responses.

DHS assigns User ID's and passwords that are used for FTP processing, e-RIN requests and Mobius report viewing. If you experience problems with this User ID or password, contact the Customer Solution Center - IT Support for DHS at 1-800-366-8768. Press '1' and then '1' to be connected with a representative.

If you experience problems with this User ID or password, e-mail the CMS Customer Solution Center - IT Support at cms.helpdesk@illinois.gov and provide the following information:

- Full Name
- Organization
- User ID (this is the id that begins with "HSD")
- Telephone number for call-back

Please note that agents process e-mailed password reset requests in the order in which they are received and use the provided telephone number to contact the requester with the new password.

If the user's information cannot be verified, the user will receive an e-mail reply suggesting that they resubmit the request with the correct information. A requester will never receive a return e-mail or voice mail that includes a password.

Should there be questions regarding the e-RIN process, please call the RIN Call Center Help Desk number: 1-800-385-0872.

SECTION X

Tables of Commonly Used Data Elements

Setting Codes

Identified in Provider Unit/Program File and Mainframe Reports

AS - Assessment
OP - Level I (Outpatient)
OR - Level II (Intensive Outpatient)
RR - Level III (Residential Rehabilitation)
DX - Detoxification
HH - Halfway House (Residential Extended Care)
RH - Recovery Home
IN - Intervention
TX - Toxicology
CM - Case Management
CR - Childcare Residential
UR - HIV
SH - Staff Hour
DF - Donated Funds Initiative (DFI)

Program Numbers

02 - Childcare Residential
05 - Level I - Methadone
27 - Level III Rehabilitation - Adult *(Medicaid only programs)*
40 - Recovery Home
41 - Case Management
42 - Intervention
43 - Level I - Adult or Adult/Youth
44 - Level II - Adult or Adult/Youth
45 - Halfway House
46 - Detoxification
47 - Level III Rehabilitation - Adult
48 - Assessment
49 - Donated Funds Initiative (DFI)
52 - Toxicology
64 - Interpreter Referral Services
78 - Level III Rehabilitation - Youth
95 - HIV
96 - HIV Early Intervention Training

CLIENT MASTER FILE UPDATE REPORT

Error Code 984 - A Previous Opening Has Not Been Closed

The DASA master file holds multiple openings for the same client/patient if they contain both an opening and a closing date. However, this file will only allow one open record with no associated closing. DARTS contains PC edits that will not allow a new opening for the same client/patient until the previous open record is closed. However, this error can still occur when the client/patient is closed in DARTS at the PC level (especially in organizations that submit data from multiple sites) but a closing is never submitted to DASA or when data is lost at the provider level and thus the provider was unable to send in a discharge or with a third party system.

Solution: The "Client Master File Update" report will display ALL accepted and rejected openings and closings and any demographic updates. Always check to ensure that openings have been accepted before submitting any additional services. This will help to avoid many errors of this type.

When this error does occur, the message will specify the opening date of the record that must be closed. All transactions are processed in date and time order. Therefore, to correct this error you must first close the previous opening before submission of the new opening. Otherwise, the same error will reoccur. Additionally, if the opening record is not correct, all services reported against that opening will also reject.

To help reduce this type of error, providers should always check the "Client Master File Update" report to make sure that openings are not in error and submit closing records for any client/patient in early intervention or outpatient who has not received services, other than case management, in over 30 days or any residential patient who has not received services, other than case management, in over 3 days. DASA also routinely deletes any opening record off the master file that has not had any reported services for over 6 months.

Error Code 982 - Duplicate Opening

This error message means that an exact duplicate of the opening is already on the master file. This error occurs most often with third party users because there is no connection to the master file to alert the user that the opening is a duplicate. Also, if a change is made to the demographic record and it is marked as an "add" instead of "change", the system will reject it as a new opening.

Solution: Examine the error report and source documentation to determine the cause of the error. If it relates to a demographic change that was erroneously submitted as an "add", the record should be resubmitted as a "change". If it was simply a duplicate opening submission, nothing needs to be done.

Error Code 980 - Cannot Change Due to a Service Date Outside of the Opening Date Range

This error occurs when a change is sent for the opening date and a service has already been accepted that would then fall outside of the new date range. The message will specify what type of service and on what date.

Solution: Examine the error report and source documentation to determine the cause of the error. If the opening date is incorrect, it cannot be changed until the accepted service is voided. The only accepted and paid services that can be voided in DARTS are those with a funding code of DC (contract funds). To void a service in DARTS, the submission must match identically to the original submission with the exception of the "Revision Code" field, which must be completed with a "V".

Error Code 981 - Cannot Delete Opening Record Due to an Accepted Service Against That Opening

No opening record can be deleted from the DASA Master File if there is an accepted service associated with that admission.

Solution: If the opening record needs to be deleted, any accepted DC service will have to voided prior to the submission of the opening record deletion. Remember the processing order of date and time. Void the service first and then delete the opening.

Error Code 987 - Cannot Change Closing Date Due to an Accepted Discharge Assessment Service

This error occurs when there is an attempt to change the closing date after a discharge assessment has already been accepted. The error message will specify the date of the discharge assessment. The discharge assessment is the final service submission that can be accepted against an open record and this service will not be accepted unless a closing is also submitted.

Solution: No service can be accepted after payment for a discharge assessment. If the closing date needs to be changed, the discharge assessment must be voided first.

Error Code 986 - This Opening Has Treatment Services. Cannot Change to an Intervention Opening

The opening record in DARTS specifies the client/patient type. This is identified through selection of “T” for treatment and “I” for Intervention and only one can be selected. The service billed against the opening record must match the client/patient type. If a treatment service is accepted against an opening record identified as a ‘T”, a subsequent attempt to change the client/patient type to “I” will be rejected.

Solution: If the client/patient type needs to be changed, void the accepted services prior to submitting the change against the opening record.

MAIN FRAME CROSS EDITS

At main frame processing, many cross edits are checked to ensure that all demographics fields are correctly completed with the proper values. The error messages that result from this checking are generally self-explanatory and are mainly the result of keystroke errors or errors in data collection. However, they must be corrected in the opening record or all services will continue to reject. The first step in correcting these types of errors is to obtain the source documentation for the data entry to determine what needs to be fixed. Some examples of these types of error messages are:

Error Code 317 - Age of first use cannot be greater than age at admission. For example, case the age of first use was submitted as 20 and the age at admission was 19.

Error Code 044 - Invalid Problem Area. This error occurs when a problem area is selected that does not match the primary problem code. For example, if "Drugs" are selected as the problem area, the primary problem code cannot be "alcohol".

Error Code 174 - Dually Diagnosed Require Both Diagnosis. This error occurs when the patient is identified as "MISA" in the opening record and there is no mental health diagnosis entered in one of the diagnosis fields.

SERVICES ACCEPTED/REJECTED REPORT

Error Code 945 - Billed amount exceeds the Medicaid allocation for this Provider. This error will cause Medicaid billings to reject as all Medicaid submissions (Funding Code "DM") are checked against the established fiscal year allocation for each provider prior to processing.

Solution: There are two possible solutions to this problem. If the Medicaid allocation is reached and contract funds remain, the service can be rebilled to contract using funding code "DC". An increase in the Medicaid allocation may be requested and may be granted if funds remain in the total appropriation. Neither of these scenarios is a sure thing and fund balances should be checked prior to re-submission.

Error Code 930 - No Matching/Unit/Program. The unit/program number used for the service billing must match one that is contained within the facility file at DASA. When this error occurs, it is held in suspense for the next five submissions in anticipation of a correction to the submission. If this does not occur, the service will have to be resubmitted.

Solution: Verify that you using the most current update to your software. This is particularly important if you have relocated a facility or ended or started a new funded service. Often when this occurs, reporting numbers change or are given new begin and end dates. If you determine that you are using the most current unit and program file, it will be necessary to contact the DASA Help Desk as the error may be in our files.

Error Code 931 - Service not within the contract date range (begin and end date) for the associated unit/program number. A submitted service cannot have been delivered on a date that in not within the begin and end date for the associated reporting unit/program number. When this error occurs, it is held in suspense for the next five submissions in anticipation of a correction to the submission. If this does not occur, the service will have to be resubmitted.

Solution: Verify that you using the most current update to your software. This is particularly important if you have relocated a facility or ended or started a new funded service. Often when this occurs, reporting numbers change or are given new begin and end dates. If you determine that you are using the most current unit and program file, it will be necessary to contact the DASA Help Desk as the error may be in our files.

Error Code 934 - No Valid Opening Record. Resubmit Record. There must be a **valid opening** for any reported service except community intervention and HIV early intervention, which is not linked to a specific client/patient. A valid opening is one with complete and correct demographic fields that has not been rejected as an error. This error frequently occurs when the opening record identifies the patient as a client/patient type "I" for intervention and a treatment service is submitted against that opening or vice versa. It also occurs when a submitted service is not within the date range of the opening record. When this error occurs, the service is held in suspense for the next five submissions in anticipation of a correction to the opening. If this does not occur, the service will have to be resubmitted.

Solution: Check all copies of the "Client Master File Update" report to ensure that the associated opening record for the submitted service has been accepted. Generally, if this error occurs, the opening record rejected and has not been corrected. All associated services will continue to reject until the opening record is corrected.

Error Code 935 - No Opening Record. Services cannot be accepted without an opening record and it should be submitted prior to submission of any service. When this error occurs, the services are held in suspense for the next five submissions in anticipation of a correction to the opening. If this does not occur, the service will have to be resubmitted.

Solution: Always ensure that the opening has been accepted on the next "Client Master File Update" report that is sent after your opening record submission. If there is a problem with the opening, correct it before submitting any additional services.

Error Code 944 - Incomplete Demographics in the Opening Record. This error generally occurs when a new demographic field or value to a field is added and the opening record has not been amended. When this error occurs, the services are held in suspense for the next five submissions in anticipation of a correction to the opening.

Solution: Generally these types of enhancements are only made by DASA at the beginning of the fiscal year. However, whenever they are made, notifications are sent indicating that the change will have to be made for any new openings or to existing open records for clients/patients who continue to receive services. Be sure to make all demographic changes as soon as they are required.

Error Code 921 - Duplicate Service. This error occurs when an exact duplicate of the service has already been accepted or where service dates/times conflict.

Solution: Determine what caused the duplicate submission. If the most recent submission was sent in error, no correction to the submission is necessary, as it will not be resubmitted. However, examination is needed to determine why duplicates were submitted and corrective action should be implemented to prevent such submissions in the future.

If there is a service/date time conflict, determine which submission is correct. If the second submission is correct, the first submission will have to be voided before the second submission can be accepted.

Error Code 962 - Assessment is After Another Service Date. Once a treatment or an intervention service is delivered, submitted and accepted, no assessment service submission can be accepted if it occurred after the treatment or intervention service. This error may occur because the wrong activity code is used for a discharge assessment vs. an admission assessment.

Solution: Adopt internal practice to ensure that all clinicians know that submission of an admission assessment service cannot occur after submissions for intervention or treatment services have been accepted. The billing for assessment is for admission (pre-treatment) and discharge (post-treatment) purposes only. Ensure that the correct activity code is used for admission assessment (70) and discharge assessment (71).

Error Code 954 - No Valid Opening Record - Pharmacy Patient. This error occurs when a DASA funded Opioid Maintenance Therapy (OMT) patient has a submitted service on the Pharmacy Log but no valid opening in the DASA master file. A valid opening is one with complete and correct demographic fields that has not been rejected as an error. Generally when this error occurs with an OMT patient it is because there may be an old opening record on the Master file that does not match the date range for the OMT service. No payment for the pharmacy service can be authorized by DASA until there is a match to a valid opening record in DARTS.

Solution: Check all copies of the "Client Master File Update" report to determine the error. This may involve checking source documentation related to demographic fields. Correct the error or submit a new opening record if the invalid opening relates to a previous treatment episode. Once submitted, check the "Client Master File Update" to ensure that the opening was accepted.

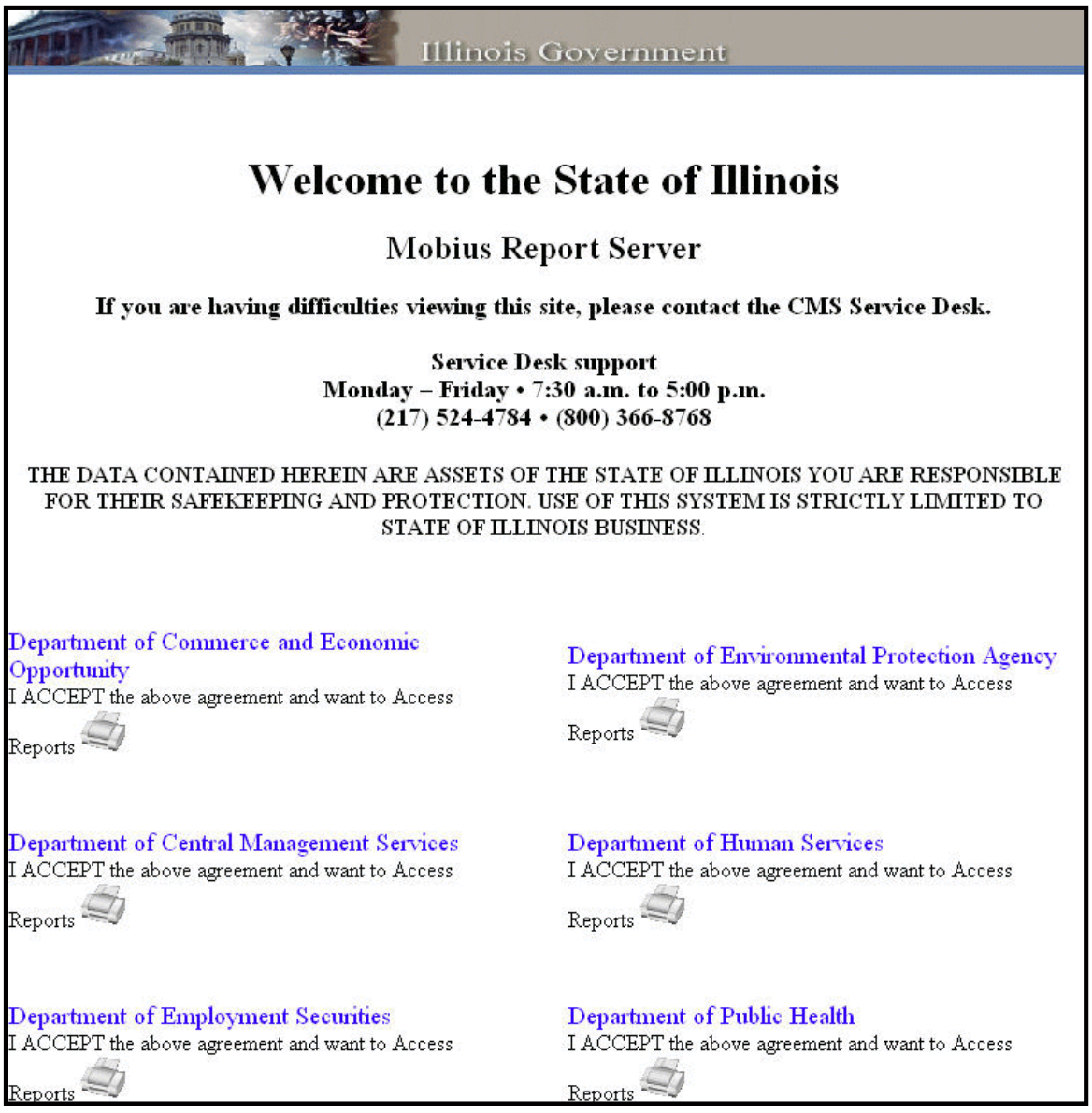
Error Code 955 - No Opening Record - Pharmacy Patient. Every DASA funded patient on the Pharmacy Log must have an open record in the DASA master file. This error occurs when the only funded service is OMT and no opening record for the patient has ever been submitted to DASA. In order for payment to be processed, the patient must be on the pharmacy log and have a valid opening at DASA.

Solution: Complete and submit an opening record for the patient.

Accessing and Using Mobius Document Direct

Use the following Web address to access Mobius Document Direct: https://reports.illinois.gov.

NOTE: It is strongly advised that you turn your popup blocker off while using this website.



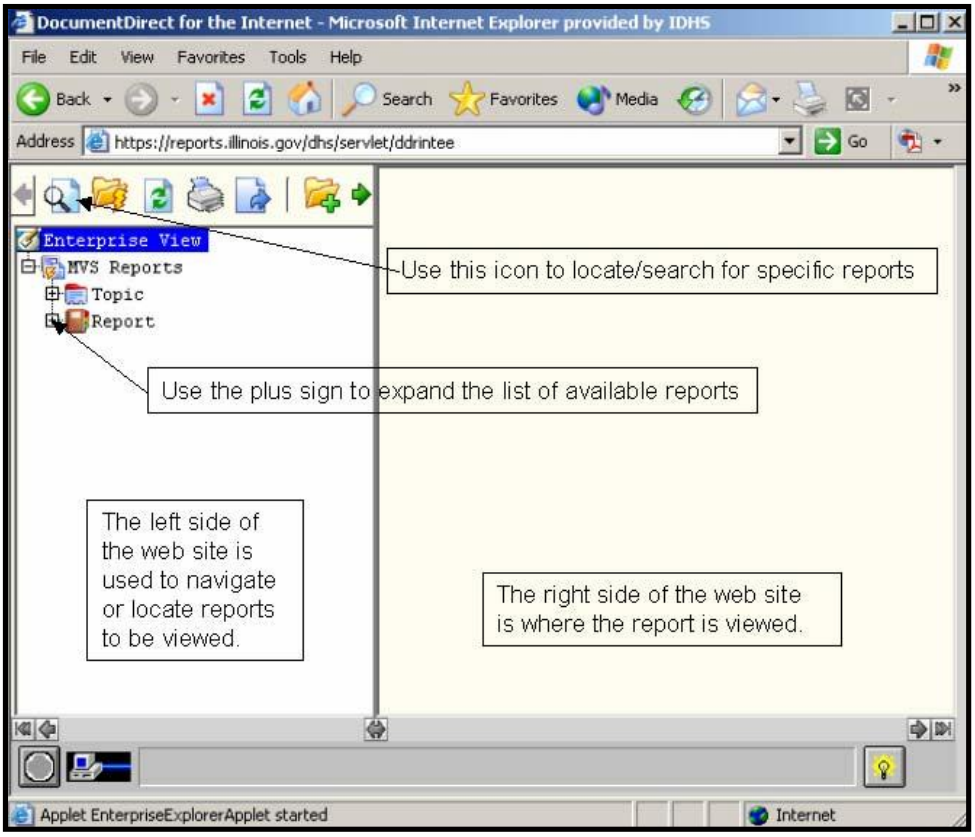
Click the printer icon “Department of Human Services” on the Mobius Report Server screen to enter the site.

Select “Yes” on the Security Informatio Window to continue.

The following window will appear. Enter your DHS User ID and password, then click on the green circle with the check mark.

The following screen appears after successful log on.

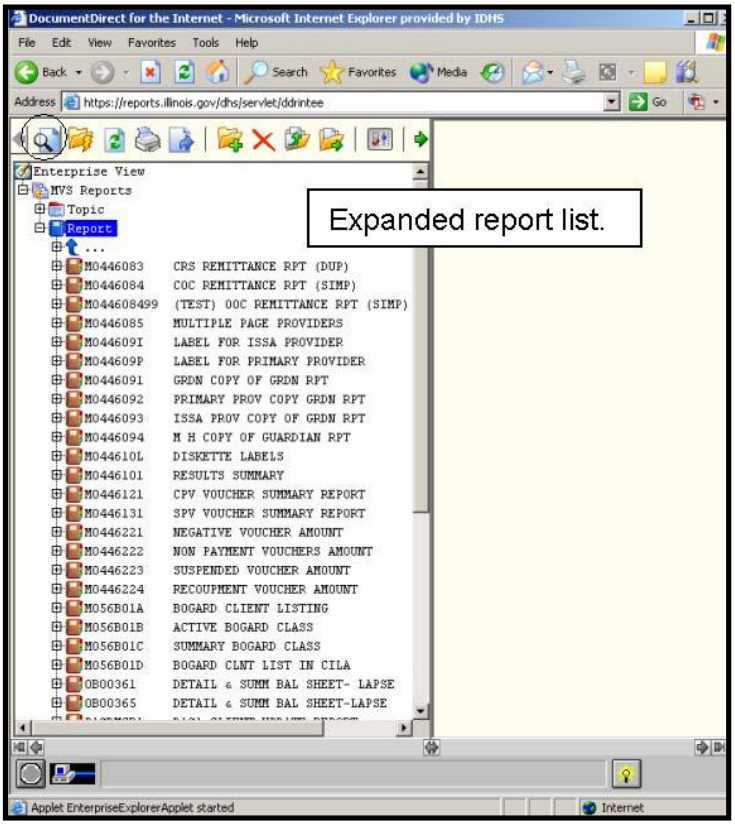
NOTE: This website does not allow you to update or change your password. If your password is revoked, you will need to contact the CMS Service Desk for assistance (1-800-366-8768, first menu option will be 2, second menu option will be 11).



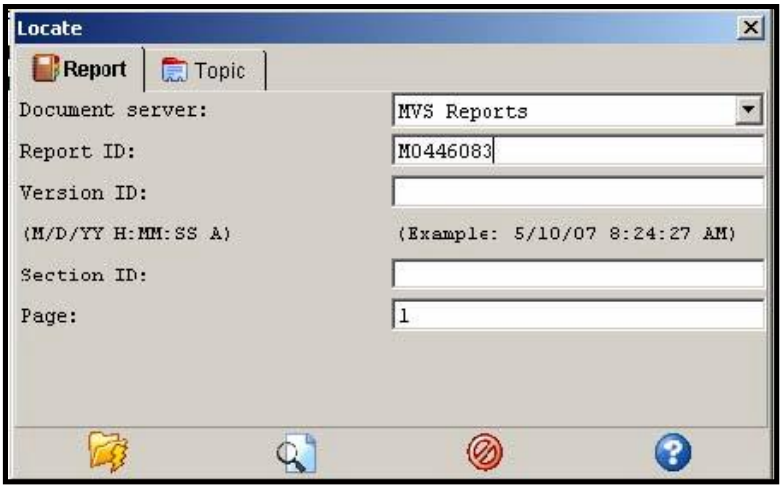
Click on the plus sign to the left of "Reports" to display the list of reports generated by the DHS MIS Unified Health Systems Section on the left side of the screen.

The reports are listed in alphabetic order by report ID. If your community agency does not submit data for all UHS Systems, some reports may not contain information. There are also reports generated for Mobius (e.g., EXITRAF) that can be ignored. Below are the report prefixes and corresponding system.

PASDM - DARTS
PDLAS - DLA
PROCS - ROCS
PPUNS - PUNS
CR/ECR - CRS (ffs)
M020 - DD Waiver
M044 - CRS (ffs)

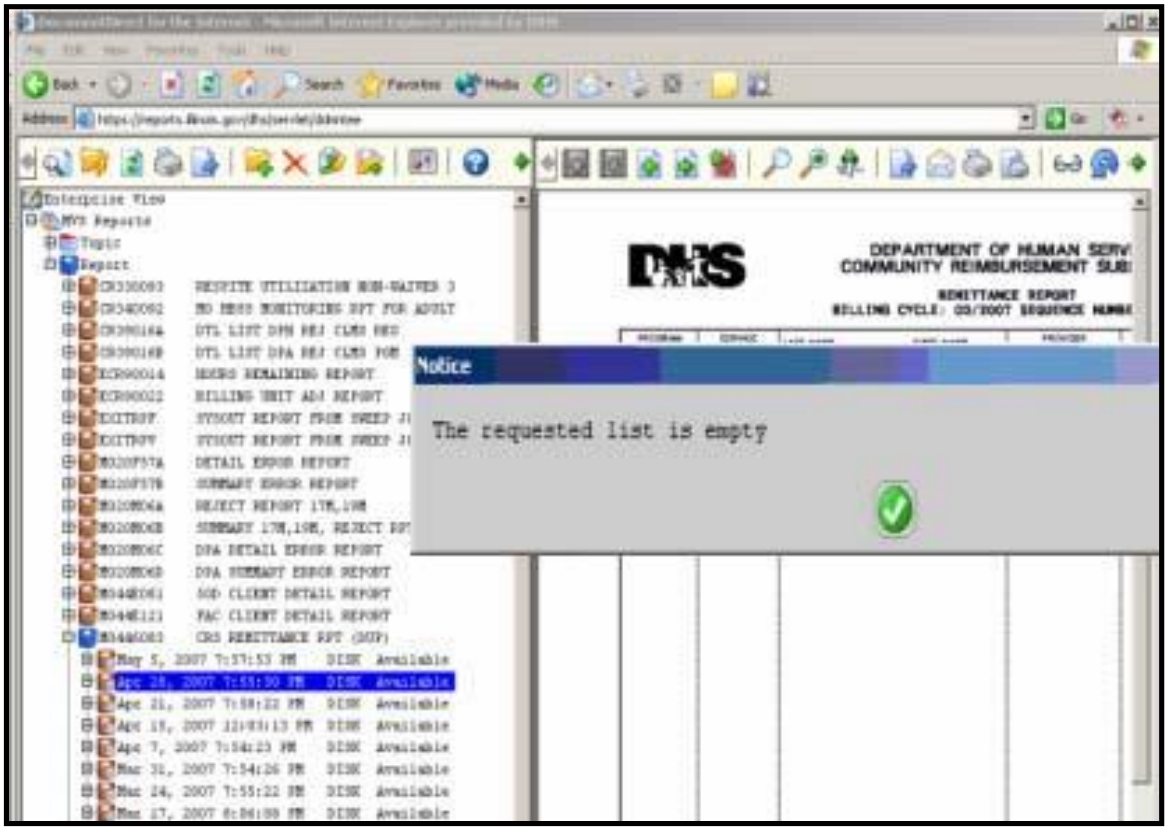


The icon can be used to search/locate a specific report. When this icon is selected, the following window will appear. Enter the Report ID in the correct space, then click on the icon at the bottom of the window to locate the report.

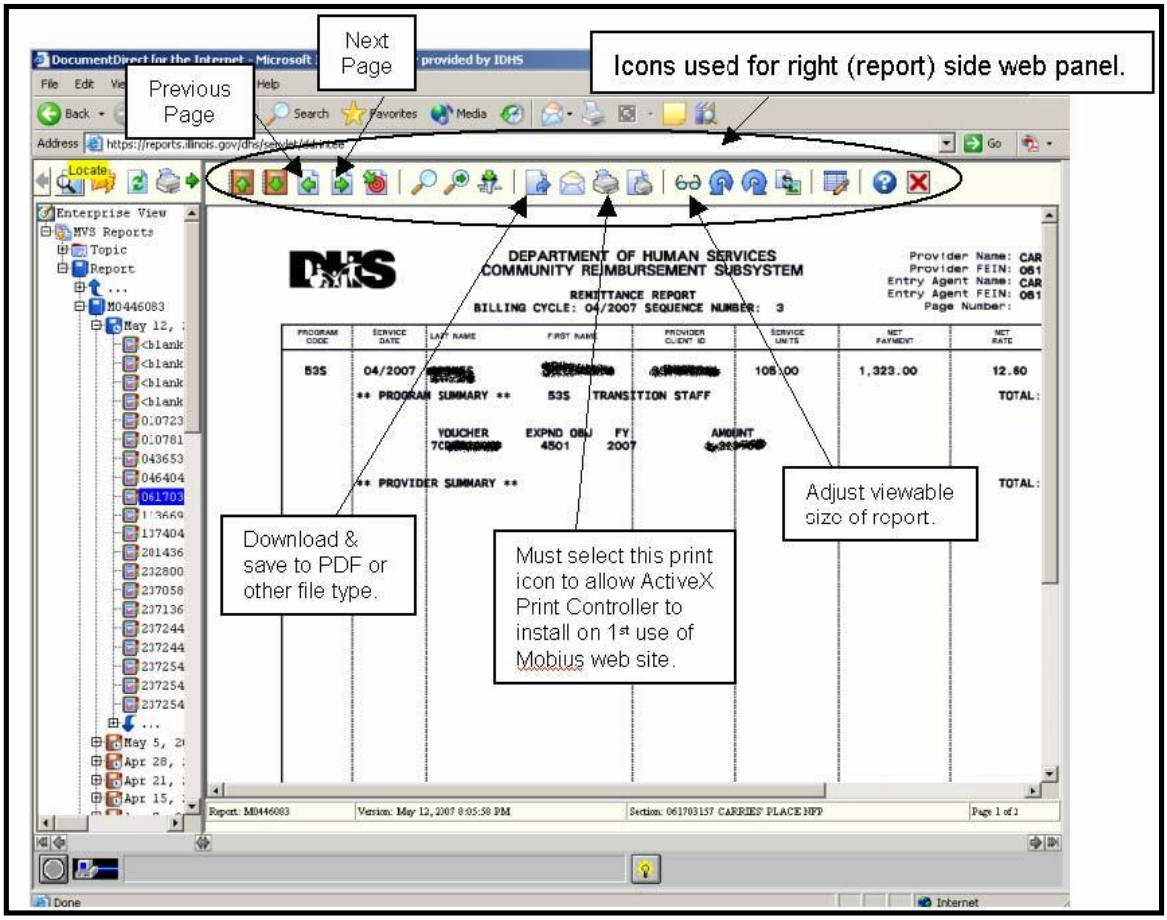


After the report is found, the left side (Enterprise View) will be populated with the date/time the report was moved to Mobius for multiple production schedules. Click on the disk icon and the report will be displayed in the window on the right side of the screen.

If an error message is received indicating, "**The requested list is empty**," this means no data was submitted by the community agency for that particular production schedule. If another date is selected and data was submitted for that production schedule, the report will appear.



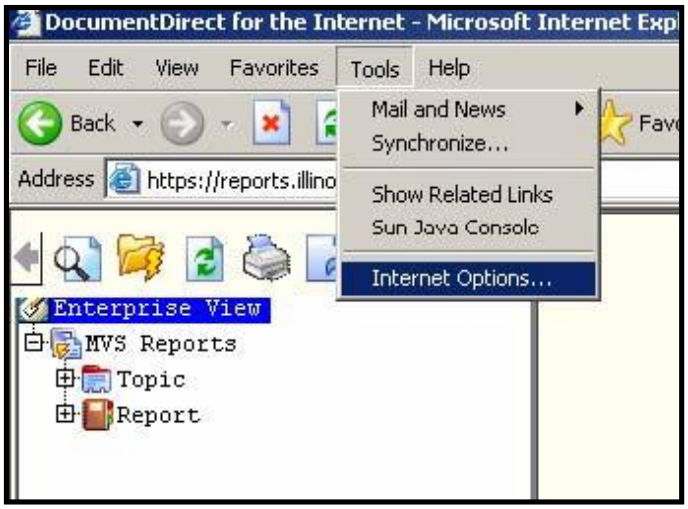
The icon shown at the top of the screen may be used to search/locate specific information.



Printing:

To activate the Mobius print function, click on the larger printer icon at the top of the screen in the right panel to allow the print application (ActiveX Print Controller) to load to the computer. This only needs to be done once and takes just a few seconds. The popup blocker must be turned off for this application to download.

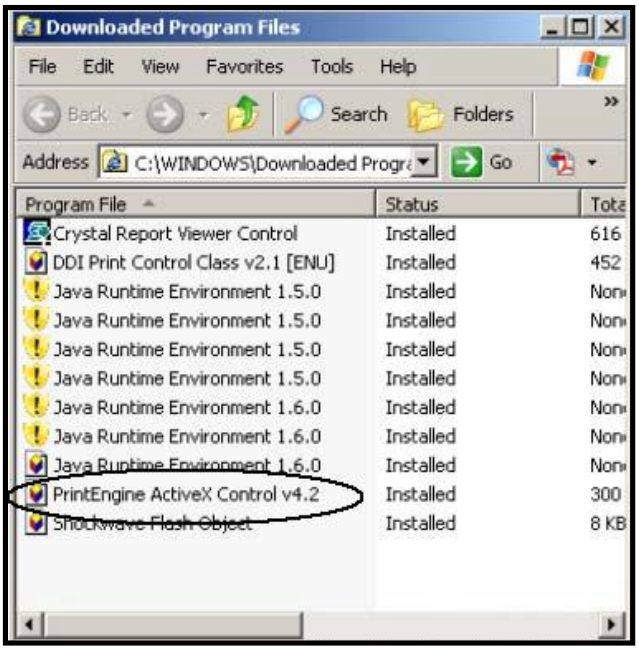
Verifying that the ActiveX Print Controller has been successfully installed:
On the Document Direct screen, select ***Tools*** from the menu bar then select ***Internet Options*** from the drop down list.



The ***Internet Options*** window will appear with the ***General*** tab displayed. Click on ***Settings*** under ***Temporary Internet files*** section of the screen.

The ***Settings*** window will appear. Click on ***View Objects***.

After the ***Downloaded Program Files*** window is displayed PrintEngine ActiveX Control v4.2 will be visible. This indicates the print control installed properly and reports from Mobius will be allowed to print.



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